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THE PROCESS OF RECOVERY
FOR
ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE:
A GROUNDED THEORY STUDY

BY

DOROTHY ANN CONSTABLE ©

A thesis
submitted to the Faculty of Graduate Studies and Research in
partial fulfilment of the requirements for the degree of
DOCTOR OF PHILOSOPHY
in
COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL 1994

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Date: Sept. 26, 1994

DEDICATION

To the memory of my father
Robert Ernest George Constable
1929 - 1990

Abstract

The purpose of this study was to develop an understanding of the process of recovery from childhood sexual abuse, based on the experience of survivors of abuse. From a practical perspective, the goals were to determine if there was an identifiable pattern of recovery and to identify therapist behaviours that facilitated recovery. From a more theoretical perspective, the goal was to use the experience of the participants in the study to generate hypotheses about the nature of the change process in general.

The results of the research are based on interviews with eleven participants, nine women and two men, referred by therapists who do extensive work with survivors of childhood sexual abuse. Interview transcripts were coded and analyzed using the constant comparative method described by Glaser and Strauss (1967) for the development of grounded theory.

Children who have been sexually abused develop representations or schemas of self and others that often guide behaviour in dysfunctional ways in adulthood. Recovery involves learning to see self and others differently. Representations of self and others are, however, not easily changed. When representations are formed in an environment of psychological threat, they become particularly rigid. In such a context, one's perceptions become constricted because of the need to focus attention on the source of threat, and one's actions become constricted because the risk of making "errors" is perceived as too high. Furthermore, information that is emotionally overwhelming may be defensively excluded from consciousness. As a result, sources of information that might alter representations of self and others are not readily available.

The establishment of a safe environment and the strengthening of one's internal resources are central in reducing the fear associated with taking risks necessary to access or generate information that will alter one's representations. In taking those risks, individuals learn to

see self and others differently; that is, the content of their representations changes. On another level, individuals also learn *how* to change; they learn to take the risks that are necessary to challenge dysfunctional beliefs, to explore new possibilities, and to create new contexts for self.

ACKNOWLEDGEMENTS

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The individuals who participated in the study for their time and their willingness to share their stories of pain and hope and their insight into the process of change. It is my sincere hope that others will benefit from that which was so freely and generously shared.

Friends and family members for their encouragement and support, in particular, to Cathy Mayhew, Sheila Pratt, Beckie Garber-Conrad, and Ellen Nygaard, who also helped with printing, and to my mother, Jean Constable, and my sister, Mary Schneck, who spent many hours helping in the preparation of the final copy of the dissertation.

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their preciousness, and for reminding me, always, about the simple things that are truly important.

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Chapter I
Introduction

In the last ten years, there has been a dramatic increase in public awareness about child sexual abuse. Along with that has been an increased focus in the professional literature on the prevalence of child sexual abuse, the immediate and long-term effects of such abuse, and the treatment of children and adults suffering from the consequences of abuse. Much of the treatment literature is anecdotal, however, and there has been little focus until very recently on the development of theoretical frameworks for treatment. The purpose of this study is the development of a theoretical framework for understanding the change process, from the point of view of adult survivors of childhood sexual abuse who have been dealing, in therapy, with issues arising from that abuse.

More specifically, research questions addressed in the study are:

1. Does recovery involve progression through any common sequence of stages, and, if so, how can those stages be conceptualized? In other words, to what extent is there an identifiable pattern of recovery, what is the range of variation associated with that pattern, and what conditions appear to be associated with the range of variation?

2. What specific changes are associated with recovery and what markers of change do clients identify? That is, how do clients understand "recovery" and what allows clients to determine that change is, in fact, occurring?

3. What do clients perceive as facilitating change or enabling it to occur? That is, are there identifiable elements introduced into the context of a client's experience that make it possible for desired change to occur? Is it possible to identify particular therapist actions that promote change?

4. What do clients perceive as blocks to change occurring? Are there identifiable constraints that must be removed or neutralized so that change can occur? Is it possible to identify particular therapist actions that inhibit change?

The research questions were developed prior to the commencement of interviews with study participants to identify the researcher's domain of interest. They were intended to function as the beginning point in an inquiry process designed to describe how adult survivors of childhood abuse perceive the change processes involved in recovery and what has helped or hindered them in that process. Within that broad framework, participants were asked to describe what was relevant for them in the process of healing. Those descriptions were then analyzed using the constant comparative method developed by Glaser and Strauss (1967) in order to develop a theoretical understanding of the change process. It is my hope that the theoretical framework developed will help therapists better understand how to assist survivors in the process of recovery as well as contributing, more generally, to our knowledge of the process of change.

Chapter II of the dissertation provides an overview of the literature regarding the prevalence of childhood sexual abuse, its long-term effects, factors influencing the development of pathological responses, theoretical conceptualizations of abuse effects, and treatment.

Chapter III describes the grounded theory approach used in the study as well as the specific procedures by which participants were sought and data were collected and analyzed in this study.

Chapter IV provides a description of the stages in the process of recovery as well as descriptions of therapist behaviours that facilitated or impeded that process for participants.

The focus of Chapter V is the development of a theoretical understanding of the process of change described by participants in the previous chapter.

Chapter VI addresses issues related to credibility, the applicability of the results to others, and possibilities for further research.

Chapter II

Literature Review

The purpose of the initial literature review in a grounded theory study is to "sensitize" the researcher to issues in the field and to provide the reader with a context in which the results of the study can be understood and evaluated. This literature review examines issues related to the prevalence of sexual abuse in childhood, the long-term psychological effects associated with childhood sexual abuse, and the treatment of adult survivors of such abuse.

Prevalence

Estimates of the prevalence of childhood sexual abuse in the general population vary significantly, ranging from 6 percent to 62 percent for females and from 3 percent to 31 percent for males, depending on a number of methodological considerations (Peters et al., 1986). Among those methodological considerations are: (a) the way in which childhood sexual abuse is defined (whether or not noncontact sexual abuse such as exhibitionism and exposure to pornography are included; whether unwanted, forced, or coercive actions of peers are included; age range of victims; and the age difference between victim and perpetrator required for an incident to be included); (b) sample size and characteristics (representativeness of population, response rates); (c) data collection techniques (questionnaires, telephone interviews, or face-to-face interviews with trained interviewers) and the context in which questions are asked (where questions are "piggybacked" onto questionnaires focusing on other unrelated or only marginally related subjects, for example, lower rates are reported). The wording of questions also appears to have a major effect on the level of reports made, with multiple, specific screening questions eliciting more positive reports than general questions about past abuse.

Perhaps the most widely reported study of sexual abuse in the general population is one conducted in San Francisco in 1978 (Russell, 1986, 1988). A community sample of 930 women, 18 years and older, were interviewed by trained interviewers. Multiple, specific screening questions were used in the interviews which lasted an average length of 80 minutes. Russell (1988) reported the results of those interviews in the following table:

Table 1

Different Measures of the Prevalence and Incidence of Intrafamilial and Extrafamilial Child Sexual Abuse (Separated)

	Women who had at least one experience (Prevalence) (N = 930)		Number of experiences of sexual abuse with different perpetrators (Incidence)*
	Sample Percentage	Number	Number
Intrafamilial abuse of females involving sexual contact under 18 years**	16	152	187
Intrafamilial abuse of females involving sexual contact under 14 years**	12	108	187
Extrafamilial sexual abuse of females involving petting or genial sex under 18 years	31	290	461
Extrafamilial sexual abuse of females involving petting or genital sex under 14 years	20	189	255

* Multiple attacks by the same perpetrator are only counted once; abuse involving multiple perpetrators is also only counted as one experience.

** 8 cases of intrafamilial abuse are excluded because of the missing data on the age of the respondent.

Source: Russell, D.E.H. (1988). The incidence and prevalence of intrafamilial and extrafamilial abuse of children. In L.E.A. Walker (Ed.), Handbook on sexual abuse of children: Assessment and treatment issues, (pp.19 - 36). New York: Springer. Copyright (c) 1988 by Springer Publishing Company, Inc., New York. Used with permission.

Combining incidents of intrafamilial and extrafamilial abuse, and reporting results based on both narrow (contact abuse only) and broad (contact and noncontact abuse) definitions, Russell (1988) reported the following prevalence rates:

Table 2

Different Measures of the Prevalence of Intrafamilial and Extrafamilial Child Sexual Abuse of Females (Combined)

	Women who had at least one experience (n = 930)	
	Sample percentage	Number
Intrafamilial and/or extrafamilial sexual abuse of females under 18 years	38	357
Intrafamilial and/or extrafamilial sexual abuse of females under 14 years	28	258
Intrafamilial and/or extrafamilial sexual abuse of females under 18 years - broad definition (includes noncontact experiences, e.g. exhibitionism, sexual advances not acted upon, etc.	54	504
Intrafamilial and/or extrafamilial sexual abuse of females under 14 years - broad definition (as above)	48	450

Source: Russell, D.E.H. (1988). The incidence and prevalence of intrafamilial and extrafamilial abuse of children. In L.E.A. Walker (Ed.), Handbook on sexual abuse of children: Assessment and treatment issues, (pp.19 - 36). New York: Springer. Copyright (c) 1999 by Springer Publishing Company, Inc., New York. Used with permission.

More recently, Finkelhor et al. (1989) report the results of a Los Angeles Times poll in 1985 which was a nation-wide random sample survey of 2630 Americans (1485 women and 1145 men) contacted by telephone and questioned for approximately one half hour on topics related to sexual abuse. Finkelhor et al. report a history of sexual abuse disclosed by 27 percent of the women in that sample and 16 percent of the men.

Saunders, Villeponteaux, Lipovsky, Kilpatrick, and Veronen (1992), in a community survey of 391 female residents of South Carolina who were 18 years or older, found that 33.5 percent had been victims of a least one form of sexual assault prior to the age of 18. Two thirds (67.7%) of the assaults involved some type of physical sexual contact, and 27.5% were defined as rapes (i.e., involving penetration). In 19.4 percent of those case, the incident was one of a series of sexual assaults. Non-contact sexual assault, experienced by one third of the respondents, included acts such as sexual exposure of the genitals, voyeurism, overt verbal threats of sexual assault, or being forced to watch pornography.

In Canada, Bagley and Ramsay (1986) report a prevalence rate of 21.7 percent in the adult female population based on a community sample in Calgary. The research was a follow-up from an epidemiological study of suicidal ideation, mental health and social background. The original sample was a stratified random sample of 679 adults, of whom 401 were women. A total of 377 were located and agreed to participate in a second interview which included questions on early sexual experiences. The results were based on reported incidents of sexual abuse, defined as "involving either someone at least three years older or someone of any age using direct force or threat to effect at least a manual assault on the child's genital area" (p. 36), up to the age of 16.

Urquiza and Keating (1990) describe a number of recent studies reporting prevalence rates for males. Urquiza (cited in Urquiza & Keating, 1990) found a prevalence rate of 17.3 percent in a population of 2,016 male students at the University of Washington where abuse was defined as direct sexual contact with an individual at least five years older than the child before the child was 18 years of age. Murphy (cited in Urquiza & Keating, 1990), using telephone interviews, reported that 11 percent of males in a community sample of 777 reported experiencing one or more of the following prior to age 18: (a) exposure by an adult, (b) fondling of sexual parts of the child's body by an adult, (c) being forced to touch an adult's body in a sexual way, (d) sexual attack or forced intercourse, (e) being forced to perform sexual acts in the presence of an adult who was taking photographs, or (f) oral or anal sex with an adult.

These studies serve to contradict the belief that childhood sexual abuse is a rare occurrence and, given the possibility of underreporting, indicate a problem of considerable magnitude.

Long-Term Psychological Effects

The study of the psychological effects of childhood sexual abuse has taken two major forms. The first involves establishing the prevalence of a history of childhood sexual abuse in particular clinical populations. The second involves correlational studies which describe particular symptoms associated with a history of childhood sexual abuse.

Prevalence of Abuse Histories in Clinical Populations

Among clinical populations, a number of studies indicate a high prevalence of physical and sexual abuse histories. Carmen, Rieker, and Mills (1984), in a chart review of 188 psychiatric inpatients found histories of physical and/or sexual abuse reported in 43 percent of the charts, and abuse was suspected in a further seven percent, despite no systematic collection of that kind of information. In 48 percent of the reported cases, sexual abuse was noted.

Bryer, Nelson, Miller, and Krol (1987), in a study of consecutive admissions to a private psychiatric hospital, found that 72 percent of the eligible female patients who agreed to participate (patients had to be capable of giving consent) reported a history of physical and/or sexual abuse on a self-administered questionnaire. For 54 percent of the women, that involved sexual abuse, either alone or in conjunction with physical abuse; and, for 44 percent of the women, the sexual abuse occurred prior to age 16.

Jacobson and Richardson (1987) interviewed 100 inpatients admitted to large, university-affiliated psychiatric hospital over a two-month period. Eighty-one percent (81%) of the patients reported a history of physical or sexual assault as a child or as an adult. The combined prevalence of childhood physical and/or sexual assault was 57 percent. With respect specifically to sexual assaults, 22 percent of the women and 16 percent of the men interviewed reported sexual abuse as a child, rates which do not differ substantially from those in the general population.

In contrast, Craine, Henson, Colliver, and MacLean (1988) found that 51 percent of a sample of 105 state hospital patients reported a history, prior to age 18, of sexual abuse defined in this study as "contacts or interactions between an adult and a child when the child is being used for the sexual stimulation of the perpetrator or another person" (p. 301).

Brown and Anderson (1991), in one of the largest studies to date, explored childhood sexual and physical abuse in adult psychiatric inpatients over 1,040 consecutive admissions. The prevalence of reported childhood abuse was 18 percent overall, with nine percent reporting sexual abuse and a further three percent reported combined sexual and physical abuse, rates again similar to those found in the general population. More female than male patients reported abuse, and histories of abuse were associated with more substance abuse problems, higher suicidality, and more frequent diagnoses of personality disorder.

In outpatient populations, prevalence rates show the same pattern as with inpatient populations. Jacobson (1989) interviewed a sample of 31 female outpatients in a university-affiliated county hospital and found histories of major physical and/or sexual assault reported by 68 percent of the outpatients. For 42 percent of the women, that history involved sexual assault prior to age 16. Surrey, Swett, Michaels, and Levin (1990), in a survey of 140 women outpatients obtained similar results. Sixty-four percent (64%) of the women reported a history of sexual or physical abuse, with 37 percent of the sample reporting sexual abuse at some time in their lives. Several recent studies have investigated the prevalence of sexual abuse histories in male psychiatric patients. Metcalfe, Oppenheimer, Dignon, and Palmer (1990) found a history of sexual abuse in 23 percent of a sample of 100 male psychiatric patients using a self-report questionnaire (the Sexual Life Events Inventory). In a study by Swett, Surrey, and Cohen (1990) of male psychiatric outpatients, 48% reported histories of sexual abuse and/or physical abuse. Thirteen percent (13%) reported a history of sexual abuse.

As with prevalence studies in community samples, part of the variability in rates is related to methodological issues. In the Bryer et al. (1987) study, for example, significant numbers of patients eligible to participate did not participate (100 valid interviews were obtained from among 237 eligible patients). Furthermore, interviews were conducted shortly after admission and were, in some cases, as short as 15 minutes. It is reasonable to assume, based on that information, that results may well underestimate the extent of childhood sexual abuse in that particular sample. It is, however, not always as easy to account for the significant disparity in prevalence rates, and often, it appears that rates are not markedly different from rates in the general population.

One other possible explanation for that variation is that the clinical populations which are sampled may differ significantly in diagnostic composition. That argument receives some support from evidence that suggests that a history of childhood sexual abuse is more prevalent in patients with particular psychiatric diagnoses.

Of note in that regard is the very high prevalence of childhood sexual abuse in adults with multiple personality disorder. Putnam, Guroff, Silberman, Barban, and Post (1986) report significant childhood trauma involving sexual abuse in 83 percent of 100 cases of individuals with a diagnosis of multiple personality disorder. Schultz, Braun, & Kluft (1989) found a history of sexual abuse in 86 percent of 355 individuals with a diagnosis of multiple personality disorder, and Ross, Norton, and Wozney (1989) found a history of sexual abuse in 79 percent of 236 individuals with that diagnosis. A second study by Ross, Miller, Bjornson, Reagor, Fraser, & Brown (1991), designed to obtain more detailed information about the childhood physical and sexual abuse of patients with MPD, obtained reports of childhood sexual abuse by 90 percent of the 102 individuals interviewed.

A number of researchers have also found high rates of childhood sexual abuse in psychiatric patients with a diagnosis of borderline personality disorder (Briere & Zaidi, 1988; Gross et al., 1980-81; Herman, 1986). In a comparative study of subjects with borderline personality disorder or borderline traits and nonborderline subjects with closely related diagnoses, Herman, Perry, and van der Kolk (1989) found that significantly more borderline subjects (81%) gave histories of major childhood trauma, including 68% who reported a history of sexual abuse. In another study comparing adults diagnosed with borderline personality disorder with a comparison group of depressed subjects, Ogata, Silk, Goodrich, Lohr, Westen, and Hill (1990) found that significantly more borderline subjects (71%) reported a history of childhood sexual abuse. A history of neglect or physical abuse without sexual abuse did not differentiate the two groups.

Childhood sexual abuse has also been implicated in eating disorders. Root and Fallon (1988), noting similarities in the symptom profiles of bulimics and individuals with physical victimization experiences, interviewed 172 consecutive applicants to a Bulimic Treatment Program in Seattle, Washington. Physical victimization was reported by 65.7 percent of the applicants; 28.5 percent had been sexually abused as a child. Hall, Tice, Beresford, Wooley, and Hall (1989) found that 50 percent of 158 anorexic and bulimic patients admitted to an eating disorders clinic had a history of sexual abuse, although some reports were not made until patients had been in therapy for months. Palmer, Oppenheimer, Dignon, Chaloner, and Howells (1990), in a study that sought to identify the prevalence of child sexual abuse defined as sexual contact before age 13 when someone over 16 years of age, or, between ages 13 to 15, with someone at least five years older, found that 31.1 percent of 158 women admitted to an eating disorders clinic reported such experiences. A further 26.6 percent reported unpleasant or coercive sexual experiences that did not meet the above criteria.

Steiger and Zanko (1990), observing that prevalence rates were similar to those reported in a heterogenous psychiatric population, and, in some cases with the general population, designed a study to compare women diagnosed as anorexic restrictors, anorexic bingers, bulimics with an anorexic history, and bulimics with no prior anorexia with a general psychiatric control group and a normal control group. Approximately 30 percent of the eating disordered women reported childhood sexual trauma, a rate which was comparable to the general psychiatric control group, but significantly higher than the normal control group. Significantly different rates were found, however, between anorexic restrictors and women with bulimic patterns of bingeing and purging. Studies conducted by Waller (1992) found a similar pattern of results. Waller also found that the frequency of bulimic symptoms was higher when the reported sexual abuse was intrafamilial, involving force, or when it occurred before age 14. He also found that, while eating attitudes are mediated by self-esteem and family interaction variables, bulimic symptoms are directly associated with sexual abuse variables.

Recently, Herman (1992a) has suggested that the physiological effects of exposure to repetitive trauma in childhood may result in a high incidence of somatic disorders among individuals with a history of childhood sexual abuse. Reports of tension headaches, gastrointestinal disturbances, and abdominal, back, or pelvic pain are commonly reported by abuse survivors (Herman, 1992a). The clinical literature also reports high rates of childhood sexual abuse among individuals with a variety of medical conditions including chronic pelvic pain (Walker, Katon, Harrop-Griffiths, Holm, Russo, & Hickok, 1988), premenstrual syndrome (Miccio-Fonseca, Jones, & Futterman, 1990; Paddison, Gise, Lebovits, Strain, Cirasole, & Levine, 1990), irritable bowel syndrome or inflammatory bowel disease (Walker et al., 1993), paradoxical vocal cord dysfunction (Freedman, Rosenberg, & Schmaling, 1991), and hysterical seizures (Goodwin, Sims, & Bergman; Gross; LaBarbera& Dozier; cited in Lowenstein, 1990). For somatization disorders, that is, physical conditions attributed to psychological causes, there is some evidence of an association with a history of childhood trauma, although there has been little systematic investigation of that relationship. One exception is a study by Morrison (1989) comparing the prevalence of sexual molestation in childhood in a sample of women with somatization disorder and a sample of women with primary affective disorders. Significantly higher rates of childhood sexual molestation were found in the group of women with a diagnosis of somatization disorder (55% vs. 16%).

Symptoms Associated with Childhood Sexual Abuse

The second means of determining the psychological effects of childhood sexual abuse is to identify individuals with a history of abuse and to look at their general level of psychological adjustment. There have been a relatively large number of studies which have examined the correlation between a history of childhood sexual abuse and various problems or symptoms. Among the effects documented in the literature are:

1. Sexual problems, including difficulty with arousal, nonorgasmia, dyspareunia, vaginismus, flashbacks, sexual guilt, sexual anxiety, low sexual self-esteem, and low sexual satisfaction in women with history of childhood sexual abuse (Becker et al. 1982; Becker et al., 1986; Briere, 1988; Courtois, 1979; Finkelhor, 1984; Finkelhor et al., 1989; Herman, 1981; Jackson et al., 1990; Langmade, 1983; Meiselman, 1978; Saunders et al., 1992). Westerlund (1992), in an extensive study of the effects of childhood sexual abuse on women's sexuality, reported effects in the following areas: body perception and reproduction, sexual preference and sexual "lifestyle" (aversion, inhibition, compulsion, celibacy, "promiscuity," prostitution, sex-intimacy "splits," masochistic sexual patterns), and sexual functioning, including disturbed sexual fantasies. Among men, several problems related to sexual behaviours have been reported, including sexual dysfunction, sexual compulsiveness, sexual preference conflict, sexual fantasies or sexual attraction toward children, dissatisfaction with sexual relationships, lower sexual self-esteem, and sexual identity concerns (Dimock, 1988; Urquiza & Capra, 1990). Associations between high risk sexual behaviours related to increased HIV vulnerability and a history of childhood sexual abuse have also been reported for both men and women (Allers et al., 1993; Zierler et al., 1991).

2. Depression, guilt, negative self-evaluation (Bagley & Ramsay, 1986; Briere & Runtz, 1988; Courtois, 1979; Garnefski, et al., 1990; Gold, 1986; Herman, 1981; Hunter, 1991; Jackson et al., 1990; Jehu, Gazan, & Klassen, 1984-85; Peters, 1984; Saunders et al., 1992; Sedney & Brooks, 1984; Stein et al., 1988; Urquiza & Crowley, cited in Urquiza & Capra, 1990) and increased suicidality (Briere & Runtz, 1986;

Briere et al., 1988; Brown & Anderson, 1991; Ensink, 1992; Saunders et al., 1992; Sedney & Brooks, 1984).

3. Higher levels of anxiety and chronic tension (Bagley & Ramsay, 1986; Briere & Runtz, 1988; Murphy et al., 1988, Saunders et al., 1992; Sedney & Brooks, 1984; Stein et al., 1988), and more obsessive-compulsive symptoms (Saunders et al., 1992; Murphy et al., 1988).

4. High levels of somatization (Briere & Runtz, 1988; Cunningham et al., 1988).

5. Disturbances in perception, specifically, hallucinatory experiences (Ellenson, 1986; Ensink, 1992).

6. Cognitive "distortions," including distorted self-perceptions, dysfunctional attributions, dichotomous thinking (Fine, 1990; Gold, 1986; Henschel et al., cited in Briere, 1992; Jehu, 1988).

7. High levels of dissociation (Briere & Conte, 1989; Briere & Runtz, 1988; Chu & Dill, 1990; Ensink, 1992; Sanders & Giolas, 1991; Shearer et al., 1990; van der Kolk et al., 1991).

8. Increased likelihood of substance abuse (Briere, 1988; Brown & Anderson, 1991; Herman, 1981; Miller et al., 1987; Peters, 1984; Singer et al., 1989; Stein et al., 1988; Swett et al., 1991; Urquiza & Crowley, cited in Urquiza & Capra, 1990).

9. Increased likelihood of other self-injurious behaviors such as self-mutilation (Briere, 1988; Briere & Zaidi, 1988; de Young, 1982; Lindberg & Distad, 1985b; van der Kolk et al., 1991).

10. Apparent vulnerability to revictimization later in life, including higher rates of subsequent rape or other sexual victimization (Briere, 1988; Fromuth, 1986; Herman, 1981; Kluft, 1990; Miller et al., 1978; Russell, 1984; Wyatt, Guthrie, & Notgrass, 1992) and higher rates of spousal abuse (Briere & Runtz, 1988; Russell, 1986). Attributional style, learned helplessness, number of partners (Mandoki & Burkhart,

1989), and use of dissociation as a coping behaviour (Kluft, 1990) have all been suggested as factors related to increased vulnerability to revictimization.

11. Interpersonal problems, particularly in intimate relationships (Dimock, 1988; Herman, 1981; Hunter, 1991; Jackson et al., 1990; Meiselman, 1978), marital disruption (Finkelhor et al., 1989), difficulties parenting (Cole & Woolger, 1989; Cole et al., 1992; Goodwin et al., 1981), aggressiveness/problems with anger (Briere et al., 1988; Murphy et al., 1988; Pollock et al., 1990), heightened interpersonal sensitivity (Courtois, 1979; Murphy et al., 1988; Russell, 1986), and distrust of others, (Briere & Runtz, 1987; Courtois, 1979; Gelinas, 1983; Herman, 1981; Murphy et al., 1988).

12. Symptoms of post-traumatic stress disorder, including intrusive events such as flashbacks and nightmares as well as symptoms of "emotional numbing" such as feelings of detachment or psychogenic amnesia (Briere & Runtz, 1987; Donaldson & Gardener, 1985; Goodwin, 1984; Lindberg & Distad, 1985a; Rowan et al., 1994; Saunders et al., 1992). Herman (1992a) has argued that the prolonged, repeated trauma often associated with a history of childhood abuse can result in a complex form of post-traumatic stress disorder. Complex PTSD is distinguished from simple PTSD (associated with more circumscribed traumatic events) by: (a) symptoms that are "more complex, diffuse, and tenacious" (Herman, 1992a, p. 379) than in simple PTSD, (b) characterological disturbance, particularly "deformations of relatedness and identity" (p. 379), and (c) "vulnerability to repeated harm, both self-inflicted and at the hands of others" (p. 379).

In sum, studies conducted to date clearly suggest that a history of childhood sexual abuse is a risk factor for a broad range of problems in adulthood. It is also clear, however, that not all victims of childhood abuse experience significant problems in adulthood (see, for example, Stein et al., 1988).

As a result, researchers have begun to move beyond the simple documentation of effects in attempts to understand differences in the responses of individuals abused in childhood and the particular processes underlying the development of pathological responses.

Factors in the Development of Pathological Responses

There have been several approaches taken in determining factors that distinguish individuals who have severe problems in adulthood from those who do not. One of these approaches has been to attempt to identify aspects of childhood sexual abuse associated with poorer levels of psychological functioning in adulthood, the assumption being that certain "abuse characteristics" lead to a greater degree of traumatization. Factors which have been associated with greater traumatization include sexual abuse involving fathers or stepfathers (Finkelhor, 1979; Russell, 1986), intercourse vs. fondling or noncontact abuse (Bagley & Ramsay, 1986; Briere, 1988; Russell, 1986), use of force (Bagley & Ramsay, 1985; Finkelhor, 1979; Fromuth, 1986; Russell, 1986), frequency of abuse (Russell, 1984; Tsai, Feldman-Summers, & Edgar, 1979), duration of abuse (Briere, 1988; Russell, 1984; Tsai et al., 1979), lifetime number of perpetrators (Briere, 1988; Russell, 1986), and "bizarreness" which Briere (1988) defines as sexual abuse associated with black magic or satanic rituals, bestiality, sexual torture, multiple perpetrators per act, and anal or vaginal insertion of objects.

A second approach has been to identify factors associated with fewer problems, both in childhood and in adulthood. Factors that have been identified as capable of moderating the negative effects of childhood sexual abuse are social support and certain personality characteristics that appear to act as protective factors. Social support appears to be important both in terms of ameliorating the immediate effects for children as well the long-term effects in adults. Conte and Schuerman (1987) found that children who had a supportive relationship with an adult or a supportive relationship with a sibling had significantly fewer symptoms than children without such relationships. Everson, Hunter, Runyon, Edelsohn, and Coulter (1989), in a study of the effects of maternal support following disclosure of sexual abuse, similarily found that the level of maternal support (defined as emotional support, belief of child, and action toward perpetrator) was strongly predictive of the child's initial psychological functioning. In relation to long-term effects, social support has also been identified as a factor in the lives of individuals who show no major signs of cognitive, sexual, or psychosocial disturbance as adults (Gilgun, 1990; Kaufman & Zigler, 1987; Wyatt & Mickey, 1987).

The concept of resilience, developed in the context of developmental psychopathology, has also been used to explain different responses to childhood sexual abuse (Gilgun, 1990). In particular, Gilgun cites positive self-concept and sensitivity to the internal states of self and others as attributes that act to protect individuals from the development of psychopathology in adulthood. In a study of adolescent victims of maltreatment, Moran and Eckenrode (1992) found that internal locus of control for good events and high self-esteem interacted with maltreatment to reduce the incidence of depression. Moran and Eckenrode further found that adolescents who first experienced maltreatment during childhood were significantly less likely than adolescents who first experienced maltreatment during adolescence to have those protective personality characteristics. That finding is consistent with other research on resilience which associates the presence of protective personality characteristics and the ability to develop supportive relationships in adulthood with secure attachment relationships in infancy and early childhood (Cicchetti, 1987; Luthar & Zigler, 1991).

Early studies which focused on abuse characteristics to explain the variability in degree of symptomatology rarely considered the interpersonal or familial context in which the abuse occurred. Family context, however, has the potential to aggravate the negative effects of childhood sexual abuse as well as having the potential to ameliorate those effects. In fact, some researchers (Alexander & Lupfer, 1987; Harter, Alexander, & Neimeyer, 1988; Nash et al., 1993) have suggested that the pathogenic effects of childhood sexual abuse are related primarily to the dysfunctional nature of families in which sexual abuse occurs. That position has not been supported in a number of studies (Conte et al., 1989; Elliott & Briere, cited in Briere & Elliott, 1993; Wyatt & Newcomb, 1990) where factors such as severity of the abuse (intrusiveness, degree of coercion, number of incidents) show direct (nonmediated) effects on adult functioning. The research by Alexander and her colleagues, however, has clearly shown that the family context in which sexual abuse occurs is an important variable in understanding the long-term effects of childhood sexual abuse.

Alexander (1992) has also argued that the environment in which abuse occurs, specifically, the nature of the attachment relationships with significant caregivers, influences the pattern of long-term effects exhibited in adulthood. In particular, she hypothesizes that different patterns of insecure attachment (avoidant, resistant, disorganized) are related to three different types of abusive family environments characterized, respectively, by rejection, role reversal or parentification, and fear or unresolved parental trauma. The three types of insecure attachment are further hypothesized to result in different patterns of interpersonal problems, affect regulation, and disturbances of self.

Similarly, the developmental level of the child at the time the abuse occurred, particularly at the time the abuse began, has been posited as a major factor in understanding the differential effects of sexual abuse in childhood. Cole and Putnam (1992) have argued that the field of developmental psychopathology, which examines the evolution of psychological disturbance in the context of development, provides a theoretical base for understanding the differential effects of childhood abuse. In particular, they argue that it is important to understand the developmental factors that influence a child's capacity to manage stress and specific developmental tasks that may be compromised by that stress.

A number of researchers have argued that the particular characteristics of the abuse are much less important than the meaning of a particular event(s) for the victim. The meaning of particular events is reflected in the beliefs that the individual comes to hold about self and others. McCann, Pearlman, Sakheim, and Abrahamson (1988) identify a number of common beliefs cited in the clinical literature that are held by individuals with a history of childhood sexual abuse. Those beliefs include a belief in one's inability to protect oneself from harm; a belief in the untrustworthiness of one's own perceptions and judgments; a belief that others cannot be trusted; an expectation that one will be unable to control one's own feelings or actions, or to effect change in relationships with others; a belief that one is worthless or unlovable; a belief that others are bad or malicious or uncaring; an expectation of not being able to soothe or comfort oneself; and an expectation that meaningful, satisfying relationships are not possible. Similarily, Jehu, Gazan, and Klassen (1988) note commonly held "self-blaming" beliefs (e.g. beliefs that one's compliance or lack of disclosure meant that one was to blame, that experiencing physical pleasure or emotional closeness meant one wanted the abuse, or that one must have been provocative in some way) and commonly held "self-denigratory" beliefs (e.g. that one is worthless or bad, or inadequate, or not entitled to consideration or respect).

Celano (1992) has argued that it is important to understand developmental influences on the attributions that children make about sexual abuse experienced in childhood which are related to what the abuse means for the child. She discusses the process by which children's attributions of internal responsibility develop at various stages, accounting for the prevalence of self-blame among survivors of childhood abuse. For example, she considers factors such as difficulty in differentiating feelings of self and other in early childhood, the tendency to judge behaviour in terms of its consequences rather than the actor's intentions, the inability to differentiate between a concrete act of agreement and the abstract concept of informed consent, and the self-consciousness of adolescence.

Celano (1992) also argues that children make different types of internal attributions depending on their developmental level. She suggests that internal attributions of preschoolers are associated with issues such as failure to recognize the abuse, participation in the abuse, family reaction to disclosure, and failure to seek help. For latency-aged children, she suggests that internal attributions are related to failure to avoid or control the abuse, pleasure gained, and failure to protect siblings. For adolescents, Celano suggests that the primary attribution of internal responsibility is associated with failure to protect self.

Finkelhor and Browne (1985, 1986, 1988) have argued that psychological impact of childhood sexual abuse and its behavioural manifestations in adulthood are related to the pattern of "traumagenic dynamics" involved in the abuse. Four different dynamics involved in the traumatization resulting from sexual abuse are postulated: (a) traumatic sexualization which is "the process by which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways" (Finkelhor & Browne, 1988, p. 63) and which may involve "rewards" (gifts, privileges) for sexual behavior, sexualization of affection, evocation of sexual responses, association of sex and pain, and so on; (b) betrayal, by a trusted perpetrator or by family members who responded inappropriately to disclosure (failed to protect, blamed the victim); (c) powerlessness that occurs as a result of a child's will or desires or sense of self-efficacy being contravened through coercion, manipulation, or failure of the child's attempts to halt the abuse; and (d) stigmatization or the communication of "badness," shame, or guilt through blame of the child by the perpetrator or others, denigration or humiliation of the victim, pressure for secrecy, and so on. Table 3: Traumagenic Dynamics in the Impact of Child Sexual Abuse (Finkelhor, 1987), identifies those dynamics in more detail with the associated psychological impact and behavioral manifestations postulated.

Table 3

Traumagenic Dynamics in the Impact of Child Sexual Abuse

TRAUMATIC SEXUALIZATION
- *Dynamics*
    - Child rewarded for sexual behavior inappropriate to developmental level
    - Offender exchanges attention and affection for sex
    - Sexual parts of child fetishized
    - Offender transmits misconceptions about sexual behavior and sexual morality
    - Conditioning of sexual activity with negative emotions and memories
- *Psychological Impact*
    - Increased salience of sexual issues
    - Confusion about sexual identity
    - Confusion about sexual norms
    - Confusion of sex with love and care getting/care giving
    - Negative associations to sexual activities and arousal sensations
    - Aversion to sex intimacy
- *Behavioral Manifestations*
    - Sexual preoccupations and compulsive sexual behaviors
    - Precocious sexual activity
    - Aggressive sexual behaviors
    - Promiscuity
    - Prostitution
    - Sexual dysfunctions; flashbacks, difficulty in arousal, orgasm

- Avoidance of or phobic reactions to sexual intimacy
- Inappropriate sexualization of parenting

STIGMATIZATION
- *Dynamics*
    - Offender blames, denigrates victim
    - Offender and others pressure child for secrecy
    - Child infers attitudes of shame about activities
    - Others have shocked reaction to disclosure
    - Others blame child for events
    - Victim is stereotyped as dangerous goods
- *Psychological Impact*
    - Guilt, shame
    - Lowered self-esteem
    - Sense of differentness from others
- *Behavioral Manifestations*
    - Isolation
    - Drug or alcohol abuse
    - Criminal involvement
    - Self-mutilation
    - Suicide

BETRAYAL
- *Dynamics*
    - Trust and vulnerability manipulated
    - Violation of expectation that others will provide care and protection
    - Child's well-being disregarded
    - Lack of support and protection from parent(s)
- *Psychological Impact*
    - Grief, depression
    - Extreme dependency
    - Impaired ability to judge trustworthiness of others
    - Mistrust; particularly of men
    - Anger, hostility
- *Behavioral Manifestations*
    - Clinging
    - Vulnerability to subsequent abuse and exploitation
    - Allowing own children to be victimized
    - Isolation
    - Discomfort in intimate relationships
    - Marital problems
    - Aggressive behavior
    - Delinquency

POWERLESSNESS
- *Dynamics*
    - Body territory invaded against the child's wishes
    - Vulnerability to invasion continues over time
    - Offender uses force or trickery to involve child
    - Child feels unable to protect self and halt abuse
    - Repeated experience of fear
    - Child is unable to make others believe
- *Psychological Impact*
    - Anxiety, fear

- Lowered sense of efficacy
- Perceptions of self as victim
- Need to control
- Identification with the aggressor

Behavioral Manifestations

- Nightmares
- Phobias
- Somatic complaints; eating and sleeping disorders
- Disassociation
- Running away
- School problems, truancy
- Employment problems
- Vulnerability to subsequent victimization
- Aggressive behavior, bullying
- Delinquency
- Becoming an abuser

Source: Finkelhor, D. (1987). The trauma of child sexual abuse: Two models. Journal of Interpersonal Violence, 2, 348-366.

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Theoretical Conceptualizations of Abuse Effects

Traditional theoretical frameworks for understanding the presence of psychological problems have also been used to explain the negative effects of childhood sexual abuse. Berliner and Wheeler (1987), for example, suggest that the effects of childhood sexual abuse can be conceptualized as the result of conditioned anxiety and socially learned responses to the victimization experience. Within that framework, intrusive and avoidant symptoms associated with post-traumatic stress disorder, and commonly seen in sexual abuse victims, are seen as attempts to master or cope with the anxiety produced by the traumatic experience either through approach strategies or through avoidance and denial. Anxiety is seen as resulting from the pairing of an unconditioned stimulus (fear) with previously neutral or reinforcing stimuli (offender) and the subsequent generalization and/or higher-order conditioning to other persons or stimuli similar to those associated with the abuse. While that anxiety may have been initially adaptive, as generalization occurs and as the child's developmental level and needs change, it becomes maladaptive.

In addition, Berliner and Wheeler (1987) argue that "the maladaptive social behaviors, beliefs, and attitudes learned and the adaptive ones that victims fail to learn" constitute a "second major pathway to postabuse maladjustment." Berliner and Wheeler postulate that the learning occurs through a number of processes including the offender's modeling, instruction, direct or differential reinforcement, and punishment or threat of punishment. Negative expectations about self-efficacy are further learned from the disregard of the child's wishes and feelings implicit in the sexual coercion.

In general, however, learning theory has not had a prominent role in attempts to understand the process by which childhood sexual abuse results in psychological problems in adulthood. The conceptualization of sexual abuse as trauma and the negative effects of that abuse as a form of post-traumatic stress disorder have, however, been central to many of the theories regarding the negative effects of childhood sexual abuse.

Historically, the treatment of individuals suffering from the effects of trauma first gained prominence during World War II where psychiatrists were involved in the treatment of "war neuroses." Treatment was conducted from a psychodynamic perspective and typically involved abreaction of traumatic memories, an approach that continues to be seen as important by many in the current treatment of abuse survivors.

With the increased prominence of cognitive approaches, variations have occurred in the more traditional psychodynamic understanding of the process by which traumatic events lead to particular symptoms. Horowitz (1986), for example, combines both cognitive and psychodynamic perspectives in understanding and treating "stress response syndromes." Traumatic events are seen as "information" that the individuals must integrate into their view of self, of others, and of the world. Horowitz argues that the presence of unassimilated stress information activates a "drive for completion or mastery." Defense mechanisms are seen as an individual's means of attempting to reduce levels of arousal associated with stress-related information and serve to regulate the processing of that information. Horowitz argues that individuals oscillate between intrusion and denial phases until the information is processed. Because Horowitz's model accounts for the existence of commonly occurring intrusive symptoms such as flashbacks and nightmares as well as well as the repression of memories, denial, and related strategies of emotional numbing and constriction of awareness, it is widely used as a working model in treatment.

Chemtob, Roitblat, Hamada, Carlson, and Twentyman (1988) have recently proposed a "cognitive action theory" of post-traumatic stress disorder which follows from the work of Beck and Emery on threat reaction and from Lang's cognitive anxiety theory. Lang's theory proposes that emotional stimuli are represented by individuals in propositional networks (or fear structures in the terminology used by Foa and Kozak) which contain information about the semantic content of the stimuli, associated images, valence, and appropriate behaviourial responses (e.g., avoidance, coping responses, somato-visceral responses). Although those particular concepts have not been specifically applied to the understanding of responses to childhood sexual abuse, such application can be anticipated. In fact, the commonly-accepted proposition that many problematic behaviours exhibited by adult survivors of abuse are the continuation of behaviours which had a protective function for the child during the time of the abuse is one that Lang's theory easily incorporates.

Finally, there is a growing field of work related to the psychobiology of traumatic stress. Although much of the research in that field is very technical, the basic underlying assumptions are that traumatic stress disrupts the physiological, as well as psychological, equilibrium of the person. Wilson and Walker (1989) argue that learning that occurs and beliefs that develop during periods of high physiological arousal may become state-dependent and difficult to access in other states. In some cases, there appear to be changes in nervous system functioning, resulting in chronic hyperarousal and "a cognitive information-processing style that functions in trauma-associated ways in nearly all situations" (Wilson & Walker, 1989, p. 22). Theories regarding the psychobiology of traumatic stress have been used in the explanation of abuse effects such as high levels of somatization seen in adult abuse survivors as well as events described as "re-enactments" of childhood abuse (see van der Kolk, 1989).

The conceptualization of the effects of childhood sexual abuse as a form of post-traumatic stress disorder is not without its critics. Finkelhor (1987, 1990), for example, has expressed concerns about the emphasis on the affective realm in the PTSD framework which obscures, in his view, the "significant impact in the cognitive realm" associated with distorted beliefs about self and others, sexual misinformation, and so on. While accepting that many victims of sexual abuse suffer from PTSD symptoms, he argues that the PTSD symptoms are only part of the pattern of abuse effects commonly seen. Furthermore, not all victims have PTSD symptoms; depression and sexual problems may, for example, be the predominant effects of the sexual abuse. Finally, Finkelhor suggests that the trauma associated with childhood sexual abuse is often different than the trauma experienced by individuals in response to an event(s) characterized by danger, threat, or violence which must be integrated into existing "schemata." Specifically, he argues that childhood sexual abuse is often more appropriately understood as "a situation, relationship, or process" where the trauma:

> ...derive[s] from the distorted socialization in the relationship or in the situation. The problem for the child may not be in the failure to integrate the experience into existing schemata so much as in what might be called an "overintegration" of the experience, as the distortions acquired in the course of the abuse (the relationship or situation) are applied indiscriminately in other situations where they are inappropriate. (Finkelhor, 1990, p. 329)

The conceptualization of abuse effects as resulting from "distorted" relationships is also seen among the proponents of object relations theory and self psychology. Haaken and Schlaps (1991), for example, argue that one of the pitfalls of the post-traumatic stress model is that "the relational and developmental contexts of the abuse are minimized" (p. 43). In their view, object relations theory, which emphasizes parental failures in the development of psychopathology, provides a more comprehensive framework for understanding the effects of childhood sexual abuse than a post-traumatic stress model. From a self psychology model, the lack of empathic responses by caregives similarily results in impairment in self development with resultant impairment in the ability to soothe self and regulate affect as well as impairment in interpersonal functioning.

Briere (1992) appears to be influenced by object relations theory and self psychology in his attempt to provide an organizational framework for the plethora of symptoms seen in abuse survivors. He describes impaired self-reference as involving not only negative self-evaluation but also interference in "access" to a sense of self, that is, "whether or not she or he can refer to, and operate from, an internal awareness of personal existence that is stable across contexts, experiences, and affects" (p. 43). Briere (1992) argues that:

> Without such an internal base, the survivor is prone to identify confusion, boundary issues, and feelings of personal emptiness. There is often an inability to soothe or comfort oneself adequately, leading to what appears to be overreactions to stress or painful affects. This impairment can also cause difficulties in separating self from others. The abuse survivor may have problems understanding or relating to others independent of his or her own experiences or needs...or, on the other hand, may not be able to perceive or experience his or her own internal state independent of the reactions or demands of others....Such boundary problems...are associated with a wide variety of subsequent psychosocial difficulties, including revictimization, sexual or intimacy disturbance, and, for some survivors, likelihood of victimizing others through role-inappropriate behavior. (pp. 43-44)

Briere (1992) sees the inability to soothe or comfort self adequately, together with "the overwhelming dysphoric tension experienced by many abuse survivors," as related to reliance on "primitive dissociative or dysfunctional tension-reducing responses," among which he includes substance abuse, binging or chronic overeating, compulsive sexual behaviour, spending sprees, and self-mutilation.

Rieker and Carmen (1986) also identify problems related to self development as central in the "victim-to-patient process" that links childhood sexual abuse and abuse-related problems in adulthood, specifically, psychiatric illness. Their conceptualization focuses on the "fragmented identity that derives from victims' attempts to accommodate or adjust to the judgments that others make about the abuse" (p. 360). Most prominent among those judgments, in Rieker and Carmen's view, are: "it didn't happen; it happened but it wasn't important and has no consequences; it happened but (s)he provoked it; it happened but it's not abusive" (p. 363). The accommodation alters the reality of victimization, and the victim's thoughts, feelings, and behaviors become congruent with family norms and expectations. Forces behind that accommodation are seen to be: (a) the attachment needs of children as evidenced in efforts to gain love and approval, (b) threats of retaliatory violence on the part of the offender, (c) lack of support (disbelief, failure to protect) from nonoffending others, or (d) the unacceptability of or danger associated with expressing feelings such as anxiety, fear, or rage arising from the abuse. Ultimately, according to Rieker and Carmen, "the victim gives up the right to assign personal meaning to the abuse experiences and accepts the family's assertions..." (p. 366). In order to do so, victims use a variety of defenses to "isolate and compartmentalize affects and experiences that might otherwise overwhelm them" (p. 367). Rieker and Carmen describe that process as the "defensive exclusion" of certain information from processing, either by repression or "decontexualization" of that information.

McCann and Pearlman (1990) conceptualize the effects of childhood sexual abuse in terms of "constructivist self development theory" which they describe as "a synthesis of developmental theory (Mahler, Pine, & Bergman), self psychology (Kohut), social learning theory (Rotter), and other cognitive theories (e.g. Mahoney, Piaget)" (p. 13). They argue that self develops through processes of internalization and assimilation and accommodation. In their view, the self is comprised of (a) self capacities which allow for the development and maintenance of self esteem, (b) ego resources which regulate interactions with others, (c) psychological needs which motivate behaviour, and (d) cognitive schemas which are seen as "the cognitive manifestation of psychological needs" (p. 14). McCann and Pearlman argue that cognitive schemas develop in the context of a child's relational world; the most fundamental of those schemas include beliefs, assumptions, and expectations in basic need areas (e.g., recognition, protection, dominance, independence, love and affection). In an abusive environment where basic needs are not met, McCann and Pearlman argue that generalized, negative schemas develop which form the framework within which subsequent experience is structured.

In summary, the literature related to abuse effects has shifted from simply documenting the range and frequency of abuse-related problems in adult survivors to the development of hypotheses about the processes by which certain experiences in childhood lead to problems in adulthood. Interestingly, the field of sexual abuse is one where the lines between various schools of thought regarding psychological processes underlying the development of pathological responses have been relatively permeable, leading to considerable cross-fertilization of ideas. As theories about underlying psychological processes developed, implications for treatment have increasingly taken a more central focus in the literature.

Treatment

Most of the literature on the treatment of survivors of childhood sexual abuse is clinically-based rather than research based. Many of the early articles written were simply descriptions of treatment approaches or issues that commonly arose in working with adult survivors of childhood abuse. As the understanding of the effects of childhood sexual abuse became more sophisticated and more theoretically-oriented, the literature on treatment approaches became correspondingly more sophisticated and theory-driven. In many cases, attempts to conceptualize the treatment process arise from particular understandings of the psychological processes involved in the development of abuse-related problems.

In Horowitz's stress response model, for example, the role of a therapist is seen as facilitating the integration of the information which would reduce the amplitude of the oscillation between the denial-numbing phase and the intrusive-repetitive phase. The basic principle involved in that facilitation is to assist the client in regulation. Where intrusive symptoms are causing distress, the strategy is to use rest and support to supplement weak controls. Where the denial-numbing response is operative, the strategy is to use abreactive-cathartic methods to reduce controls and, in the long-term, to reduce the need for controls by helping the client complete "ideational and emotional responses" to the stress. Table 4 describes, in more detail, the treatments that Horowitz (1986) advocates in the two states.

Table 4

Treatments of Denial and Intrusive Phases

Denial-Numbing Phase	Intrusive-Repetitive Phase
Reduces controls - interpret defences and attitudes that make controls necessary - suggest recollection	Supply structure externally - structure time and events for patient when essential - organize information Reduce external demands and stimulus levels Rest Provide identification models, group membership, good leadership, orienting values Permit temporary idealization, dependency
Encourage abreaction Encourage description - association - speech - use of images rather than just words in recollection and fantasy - Conceptual enactments, possibly also role playing and art therapy	Work through and reorganize by clarifying and educative interpretive work Differentiate - reality from fantasy - past from current schemata - self-attributes from object attributes Remove environmental reminders and triggers, interpret their meaning and effect
Reconstructions to prime memory and associations	Teach "dosing,"e.g. attention on and away from stress-related information
Encourage catharis	Support
Explore emotional aspects of relationships and experiences of self during event	Evoke other emotions e.g. benevolent environment
Supply support and encourage emotional relationships to counteract numbness	Suppress emotion, e.g. selective use of antianxiety agents. Desensitization procedures and relaxation

Source: Horowitz, M.J. (1986). Stress response syndromes (2nd edition). Northvale, NJ: Jason Aronson. Copyright (c) 1986 by Jason Aronson. Used with permission.

Horowitz's work has been very influential in the treatment of adult survivors of childhood sexual abuse. Blake-White and Kline (1985), in describing group therapy with adult survivors, use a model based on the need to facilitate the abreaction of repressed material while employing strategies to deal with overwhelming emotion or intrusive symptoms. Similarly, Cole and Barney (1987) have developed the notion of a "therapeutic window" between the extremes of denial and intrusive phases. Within this band of "more moderate distress," the "post-traumatic symptoms" are still present but are sufficiently manageable to permit "reworking" of the traumatic material.

Courtois (1988) also works primarily from a stress response syndrome model where the general goal, which she defines in Horowitz's terms, is "completing integration of an event's meaning and developing adaptational responses" (p. 176). The steps in the therapeutic process which Courtois describes, however, reflect an eclectic approach in working with adult survivors. Those steps, from Courtois' point of view, are: (a) development of a commitment to treatment and the establishment of a therapeutic alliance; (b) acknowledgement and acceptance of the occurrence of the abuse; (c) recounting (disclosing) "pertinent details of the abuse," generally seen by Courtois as information necessary to give the therapist some understanding of particular abuse dynamics; (d) breakdown of feelings of isolation and stigma through group therapy or participation in self-help groups or through bibliotherapy; (e) recognition, labeling and expression of feelings as an aid to self-understanding and self-determination; (f) resolution of responsibility and survival issues, (g) grieving, (h) cognitive restructuring of distorted beliefs and stress responses, (i) self determination and behavioral change, and (j) education and skill building (e.g. communication, decision-making, conflict resolution, sexuality, parenting.) Courtois' description of various techniques that can be used in working with adult survivors of childhood abuse also reflects a very eclectic orientation.

Briere (1989) similarily has an eclectic orientation in his work with adult survivors, although therapy principles and techniques described are all within the context of what Briere calls "survivor-oriented therapy" which "focuses on the original abuse context and relates it to later and current experiences and behavior" (p. 51). Specific therapy principles and techniques recommended by Briere, in no apparent order, include: (a) normalization, facilitated by the provision of information about prevalence, common effects, developmental needs, physiological responsivity, and so on, and facilitated by contact with other survivors; (b) facilitating emotional "discharge" in a manner that allows for closure; (c) "disrupting the abuse dichotomy" (either I am bad or my offender is bad); (d) role-playing either various people or different parts of the self with the primary goal of self-acceptance and direction of anger outward; (e) desensitization, directed at reduction of anxious reactions to certain stimuli; (f) "tape recognition" of abuse-related perpetrator statements and inferences that have become introjected; involving recognition, identification, and "disattention," (g) therapeutic restimulation, through the use of "restimulation devices" such as family photographs, (h) reframing intrusive symptomatology as a sign of healing; (i) self-control techniques (e.g. grounding, distraction, relaxation, self-talk, "leaving the scene" or "time out", writing, "portable therapist"); (j) working with the "inner child," specifically, helping the client acknowledge child-like parts and allowing the "child" to describe her experience and feelings as a means of accessing dissociated material. Although Briere (1989) draws from several schools of thought in his description of the principles and techniques of "survivor-oriented therapy," the post-traumatic stress model, with its emphasis on the recovery and integration of dissociated information, is clearly in evidence.

Principles developed in working with victims of trauma in other contexts have been used to develop general principles for what has come to be termed "post-traumatic therapy" (see, for example, Ochberg, 1988, 1991). Ochberg (1991) identifies the following as fundamental principles of post-traumatic therapy. The first, he calls the "normalization principle," which involves the explanation that "there is a general pattern of post-traumatic adjustment and [that] the thoughts and feelings that comprise this pattern are normal, although they may be painful and perplexing" (Ochberg, 1991, p. 5). The explanation that symptoms have reasons and the explanation of the part that those symptoms play in facilitating recovery is designed to provide reassurance and limit resistance or avoidance that may, ultimately, be counterproductive. The principle is important, in Ochberg's words, because "...traumatized and victimized individuals are, by definition, reacting to abnormal events...[and] may confuse the abnormality of the trauma with the abnormality of themselves" (p. 5).

The second principle described by Ochberg (1991) is that "the therapeutic relationship must be collaborative, leading to empowerment of one who has been diminished in dignity and security" (p. 5). Ochberg argues that this principle is particularly important in working with victims of violent crime because "the exposure to human cruelty, the feeling of dehumanization, and the experience of powerlessness creates a diminished sense of self" (p. 5).

The third principle that Ochberg (1991) sets out is what he calls the "individuality principle" which is the recognition that "each individual has a unique pathway to recovery after traumatic stress" (p. 5). Although there are commonalities in the physiological and psychological response to traumatic stress, trauma also has individual meaning, which means that the path to recovery is also unique in some way.

With respect to techniques, Ochberg (1991) argues for the use of a wide range of techniques including educational techniques that provide information about traumatic stress and recovery from traumatic stress, holistic health practices that ameliorate the physiologically-based effects of traumatic stress (e.g. physical activity, attention to nutrition, evaluation of stimulant use, as well as developing spiritual resources and the capacity to laugh), the enhancement of social support and social integration, and, finally, therapy (e.g., grief work, desensitization of fear responses, telling the trauma story).

Attention to the psychobiology of post-traumatic stress disorder has also focused some attention on physiological states in healing. For example, Wilson (1989), in examining some native healing practices, hypothesizes that there are "psychobiological" aspects of sweat lodge rituals that produce altered states of consciousness and "decondition the overdriven hyperaroused state inherent in PTSD" (p. 62). Others have argued that physiological responses to the stress of trauma result in the creation of an altered state of consciousness that is essentially a hypnoidal dissociative state (Rossi, 1993; Spiegel, 1986; Spiegal, 1990) and that traumatic experiences are encoded as state-bound information that is accessible only in the psychophysiological state of the individual at the time of the trauma (Rossi, 1993). For that reason, the use of hypnosis to create altered states of consciousness is seen by some as an important tool in facilitating recovery from the trauma of childhood sexual abuse (see, for example, Dolan, 1991; Malmo, 1990; Steele & Colrain, 1990).

While the recovery of dissociated or repressed memories is, in itself, seen as important by some, others have focused much more on accessing memories for the purpose of reinterpreting the events that occurred in childhood. Rieker and Carmen (1986), for example, see the "core of treatment" as helping victims to recall the abuse and "its original affects" in a controlled way and "to restore the accurate meanings attached to the abuse" (p. 369). Hartman and Burgess (1988), similarly, see the process as one involving recall and "processing" of the trauma. The steps in that process which they identify are: 1) creating a safe environment, 2) establishing "stress-reducing resources," 3) bringing the trauma to the surface, 4) "processing" the trauma, and 5) transferring the processed or integrated trauma to "past memory." Hartman and Burgess argue that the "fixed state" of "nonneutralized" memories occurs "because cognitive appraisal is limited by the child's age and/or by the distortion perpetrated by the offender" (p. 449). As a result, "sensory and perceptual domains dominate learning and the child is unable to move from a highly noxious affective state" (p. 449). Although Hartman and Burgess do not address, in any explicit fashion, what "processing" involves, one major aspect of that appears to be cognitive restructuring which focuses on reframing the child's actions as survival mechanisms to provide a framework for understanding both past and present behaviours.

Jehu et al. (1988) argue that cognitive restructuring of abuse-related distortions plays a central role in the recovery of adult survivors of childhood abuse. Jehu et al. identified self-blaming beliefs and self-denigratory beliefs as particularly salient factors in the maintenance of mood disturbances, and challenging those beliefs was seen as the basis for change in a number of areas. They also focused on interpersonal problems of survivors and used traditional cognitive-behavioural strategies to address issues such as anger management, poor assertiveness skills, and exploitation by or overdependency on partners.

McCann and Pearlman (1990) have focused on the alteration of core cognitive representations of self and others as necessary in addressing the negative effects of childhood sexual abuse. The resolution of disturbances in those schema, related to the trauma experienced in childhood, is seen as involving: (a) recognition that schemas are the cognitive manifestations of psychological needs that need to be respected, (b) exploration of the "adaptive value" of disturbed schemas, recognizing that the defensive value of certain needs and schemas must be understood before they are challenged, (c) presentation of "discrepancies," necessary for the alteration of schemas, in tolerable doses, to allow for gradual accommodation, (d) recognition that disturbed schemas may be largely unconscious (tacit), that they may be associated with powerful affective states, and that the therapeutic relationship must be considered safe before exploration of such schemas can be tolerated, and (e) a flexible treatment approach. Interestingly, although McCann and Pearlman emphasize the need to alter cognitive schemas in therapy, the general approach they take in doing so is described as "broadly psychodynamic and interpersonal" (p. 174).

For McCann and Pearlman (1990), the need to be attentive to the nature of the therapeutic relationship results from a theoretical stance in which schemas related to self and others are seen to be developed and maintained or altered in an interpersonal context. That is, the discrepant information necessary to alter existing schemas of self and others is discrepant information about the nature of relationships. Herman (1992b), similarily, focuses on the importance of relationships in the recovery from trauma:

> Recovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity, and intimacy. Just as these capabilities are originally formed in relationships with other people, they must be reformed in such relationships. (p. 133)

Meiselman (1990) identifies six principles important in the therapeutic relationship in countering the dynamics associated with childhood sexual abuse. Those principles are: (a) development of a genuinely caring relationship, (b) explicit definition of the limits and boundaries of the therapy relationship, (c) predictability and reliability, (d) sensitivity to the power aspects of the relationship, (e) guarding against role reversal, and (f) recognizing the client's right to leave and to return to deal with threats associated with dependency.

Despite the acknowledgement accorded to the importance of the therapeutic relationship, more traditional psychodynamic approaches are not extensively described in the treatment literature, despite their use in practice. Haaken and Schaps (1991) discuss the use of a feminist psychoanalytic approach in their critique of "incest resolution therapy," which focuses on childhood sexual abuse as "the unifying event around which symptomatology and emotional experience are organized, a priori" (pp. 39-40) to the neglect of other life events or "relational issues" which are significant. Haaken and Schaps also argue that incest resolution therapy tends to neglect important countertransference issues (e.g. the need to be active, the need to be the "good parent" who is protective) which results in interventions which are intrusive. Furthermore, they argue that the focus on normalizing reactions to the abuse may, in fact, serve the needs of the therapist rather than the client and limit exploration of disturbing, destructive feelings.

Kane (1989), writing from a Jungian perspective, sees the fundamental pathology associated with childhood sexual abuse as the "loss of imagination and denial of the feeling function" that occurs when "connection with the body is lost through trauma." When that connection is lost, the individual "retreat[s] into the realm of fantasy," which results in unrelatedness and vulnerability to further exploitation. Kane distinguishes between imagination which she describes as "the real and literal power of the soul to create images" and fantasy which is "a mere conceit, something ridiculous and insubstantial" (p. 25). Fantasy is associated with over-developed intuition which is ungrounded because the balance with sensation is destroyed by the trauma of the abuse. Kane argues that the balance is restored through the feeling and thinking functions. That involves permission to experience the feelings associated with the abuse and the differentiation of the feeling function. With respect to the thinking function, it involves learning to speak the truth about the abuse, neither denying the reality of the abuse nor minimizing it through the use of evasive language. The acknowledgment of that truth is essential, in Kane's view, so that a clear understanding of the experience can "replace the more painful and debilitating unconscious outpourings of hysteria" (p. 29). The ability to acknowledge the truth of the abuse and to experience the feelings associated with the abuse opens the door to imagination and the transformation of internalized negative images. While the language that Kane uses it not the language commonly found in descriptions of the recovery process, it is interesting to note that central ideas such as remembering, understanding, and the creation of new images of self are common to many of the approaches described in the literature.

Although there are a relatively large number of descriptions of therapy with adult survivors at both the level of content and process, there have been very few attempts to assess the effectiveness of various approaches. In one of the few treatment studies described in the literature, Jehu et al. (1988) report on the results of a treatment program at the University of Manitoba. The program involved treatment of three major target problems--mood disturbances, interpersonal problems, and sexual dysfunctions--and was based on "certain general conditions of a therapeutic nature together with more specific treatment procedures" (p. 42), the latter being predominantly cognitive therapy techniques. Those general conditions were, however, wide ranging in nature and it is difficult, therefore, to know what aspects of the treatment program resulted in positive change. The general conditions were: (a) a therapeutic relationship characterized by mutual feelings of liking, respect, and trust; (b) a positive prognostic expectancy; (c) exploration and disclosure; (d) acceptance and support; (e) empathic understanding; (f) causal explanation leading to a shared understanding of problems and rationale for treatment procedures; (g) repeated "exposure," that is, "repeated discussion of disturbing problems in a safe therapeutic environment" (p. 25); (h) therapist influence (suggestions and advice, permission giving and sanctioning, support and encouragement, therapist modeling, therapist self-disclosure, praise and other forms of social reinforcement); (i) mitigation of maladaptive interpersonal relationship patterns "replicated" in the therapy by a "corrective relationship" with the therapist (a relationship not involving domination, exploitation, neglect, or abandonment); (j) "instigation," specifically, encouraging and supporting a client to try out new patterns of behavior, and (k) "networking," that is, the facilitation of a client's use of community resources (alcoholism treatment programs, shelters, self-help programs, parent effectiveness training programs.)

A total of 51 women were involved in the program. One did not receive treatment focused on mood disturbances as she had previously done so as part of a pilot; 10 did not complete the initial phase of treatment; and four were unavailable for follow-up. Thirty-one of the women who completed treatment for mood disturbances did not receive any further treatment focused on interpersonal problems and/or sexual dysfunctions. Jehu et al. (1988) reported a significant decrease in distorted beliefs as measured by a belief inventory developed by them, a decrease in the proportion of individuals exhibiting clinically significant levels of depression on the

Beck Depression Inventory from 58 percent to five percent, and indications of improved self-esteem. Jehu et al. also reported that treatment focused on mood disturbances had beneficial side effects for some clients in terms of marital problems and sexual functioning.

Comparative treatment research is virtually non-existent. Alexander, Neimeyer, Follette, Moore, and Harter (1989), in what appears to be the sole comparative treatment study in the literature, compared two 10-week group formats and found no differences between the groups, although participants in both groups scored better than a wait list control on the Beck Depression Inventory and a checklist of symptoms (SCL-90-R) at the end of treatment and at follow-up six months later. Alexander et al. conclude that it is essential to begin the process of identifying those components of group therapy most associated with successful outcome and those individuals most likely to profit from group therapy.

One of the purposes of this study is to contribute to the process of identifying, in a systematic manner, those components of therapy that clients see as contributing to successful outcomes. Further, it is hoped that, by developing an understanding of the recovery process, therapists will be better able to judge the potential effectiveness of particular forms of treatment or treatment modalities at any given point in the process.

Chapter III

Method

This chapter presents the rationale for use of a grounded theory approach and describes the approach in general terms. It also describes data collection issues, the process of data analysis in a grounded theory study, and issues related to the evaluation of qualitative studies. Within the context of data collection issues in qualitative research, it describes the procedures by which informants were sought and data were collected in this particular study as well as ethical issues that were addressed.

Rationale for Study Method

Different research objectives require different research methods. Arnold (1982), for example, suggests that before one can appropriately utilize highly structured research methods (such as experimentation), two conditions must be met. One, the phenomenon one wishes to study must be highly structured, and, two, the researcher must have a clear picture of what that structure is. When those conditions do not prevail, the alternative to imposing a structure arbitrarily is to study the phenomenon using less structured qualitative research methods.

There are a variety of qualitative research methods, each with a particular purpose. Some of those methods are directed primarily at description (phenomenology, for example) and some, in addition to description, seek also, through theory development, to explain the phenomena under study. Grounded theory is an example of the latter.

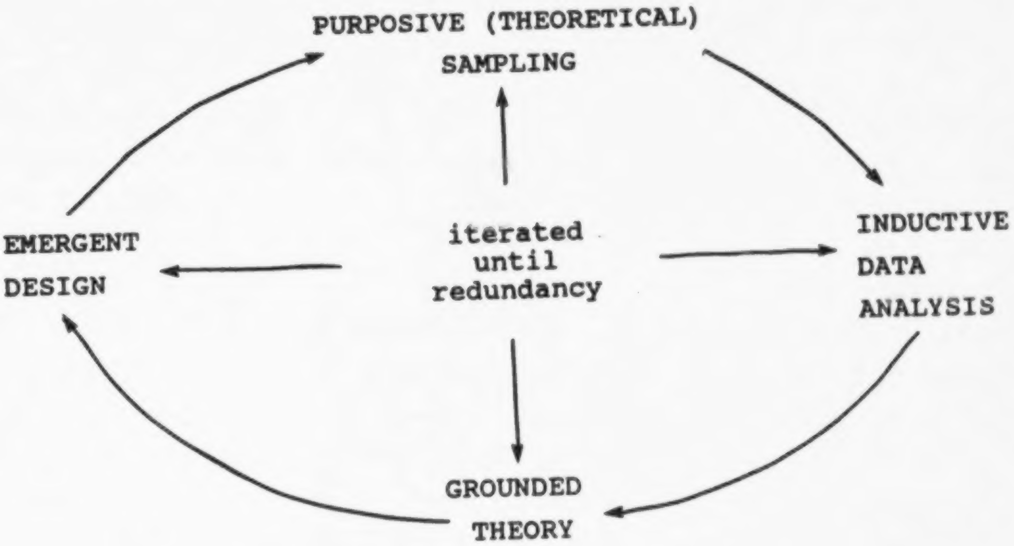
While there are a relatively large number of descriptions of treatment programs for adult survivors of childhood sexual abuse, there have been few systematic attempts to evaluate the "interventions" that therapists make in working with survivors. That evaluation requires, in my view, an understanding of the recovery process and the changes clients perceive as they move through that process as well as an assessment of the kinds of therapeutic factors and interventions that facilitate or inhibit recovery.

The process of understanding requires that one move beyond the concrete and specific to a more abstract level where patterns begin to emerge. Grounded theory is a method that allows one to move from the concrete and the specific to a more abstract level that is still, nonetheless, linked to the concrete and the specific. It allows, in other words, the development of theory that is grounded in data. Generating theory from data means, in Glaser and Strauss' words, "that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to data during the course of the research" (p. 6, Glaser & Strauss, 1967).

Strauss (1987) sees the grounded theory approach as "a style of qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density" (p. 5). Charmaz (1983) similarly focuses on a number of "fundamental strategies" associated with a grounded theory approach. Specifically, in using a grounded theory approach: (a) the focus is "discovering and analyzing social and social psychological processes" (my emphasis); (b) "data collection and analysis phases of research proceed simultaneously;" (c) "analytic processes prompt discovery and theory development rather than verification of preexisting theories;" (d) "theoretical sampling refines, elaborates, and exhausts conceptual categories;" and (e) "systematic application of grounded theory analytic methods progressively leads to more abstract analytic levels."

As Charmaz (1983) indicates, the development of a grounded theory is not a linear process. Lincoln and Guba

(1985), in speaking generally of naturalistic inquiry, conceptualize the research process in the following manner:


PURPOSIVE (THEORETICAL) SAMPLING
iterated until redundancy
EMERGENT DESIGN
INDUCTIVE DATA ANALYSIS
GROUNDED THEORY

Source: Lincoln, Y.S. & Guba, E.G. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage. Copyright (c) 1985 by Sage Publications, Inc. Reprinted by permission of Sage Publications, Inc.

This model provides, in general terms, the research framework for this study.

Data Collection

There are two main issues related to data collection. One relates to the selection of informants, and the second relates to the manner in which data are collected. The literature on grounded theory speaks to the former of those issues and very little to the latter.

Selection of Informants

The selection of informants in a grounded theory study is based on the theoretical needs of the study at any given time. The terms variously used to describe that process are theoretical sampling, or purposive or purposeful sampling. Since the primary purpose of a grounded theory study is the development of theory, informants are selected for reasons that contribute to that end. Morse (1986, 1989) argues that the selection of an appropriate and adequate sample is as critical in qualitative research as it is in quantitative research. However, the criteria for appropriateness and adequacy differ. Morse (1986) suggests that, where the appropriateness criterion for quantitative studies is representativeness of the sample, the appropriateness criterion for a qualitative study is the representativeness of the information. Where the adequacy criterion for a quantitative study is the adequacy of sample size, the adequacy criterion of a qualitative study is the quality and amount of information gathered from informants. Lincoln and Guba (1985) similarily distinguish the purpose of sampling in quantitative studies from the purpose of sampling in naturalistic inquiry. In the former, the purpose is the facilitation of generalization; in the latter, the maximization of information. What that means in practical terms is that one selects individuals who have the information sought by the researcher and who are articulate, reflective, and willing to share the information they have.

A second aspect of theoretical sampling is that purposes will change throughout the course of the study, an aspect that is perhaps most clearly reflected in Glaser & Strauss' definition of theoretical sampling: "Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges. The process of data collection is controlled by the emerging theory...." (p. 45).

Lincoln and Guba (1985), drawing from the work of Michael Quinn Patton, suggest a number of purposes other than generalizability that might direct sampling, some of which are particularly relevant to the development of grounded theory: (a) sampling typical cases, (b) maximum variation sampling,

(c) sampling extreme or deviant cases, (d) sampling critical cases, (e) sampling politically important or sensitive cases, and (f) convenience sampling.

Hutchinson (1986) indicates that, in using a grounded theory approach, one gathers information from any group which may be a source of relevant data, where "relevance is determined by the requirements for generating, delimiting, and saturating the theoretical codes" (p. 124). "Saturation" is generally considered to be the point at which continuing data collection produces only tiny increments of additional information, properties of the category are defined, and questions about relationships (e.g. causes, consequences, conditions) can be answered.

Since the focus of this study was the role of therapy in the process of recovering from the negative effects of childhood sexual abuse, a number of therapists who work extensively with adult survivors of childhood abuse were approached regarding potential participants.

In order to maximize the range of treatment variation, an attempt was made to solicit referrals from therapists with different academic backgrounds and different theoretical backgrounds. A total of seven therapists were approached regarding potential referrals. Of the five therapists who referred participants, three were psychologists, one was a social worker, and one was a medical doctor. Although the majority of the therapists would probably identify themselves as working from a feminist therapy perspective, participant descriptions of therapist techniques indicate that, technically, a wide range of interventions were used by those therapists. Most participants had also seen a number of other therapists (range in number of therapists seen was one to more than five). Experiences with other therapists were often described by participants during the course of the interview further maximizing the range of treatment variation experienced by participants. All five referring therapists were female.

Initially, therapists were asked to refer previous clients who, in their opinion, had successfully "completed" therapy or current clients who "had made substantial progress in recovering from the negative effects" of sexual abuse in childhood while in therapy. The second criterion was that individuals be sufficiently articulate and reflective to be able to describe their experience of the recovery process. Therapists were provided with a description of study and the researcher's name and telephone number to give to potential participants (Appendix A) as well as a covering letter and several stamped envelopes to facilitate contact with previous clients (see Appendix B). In all but one case, referring therapists directly approached individuals who, in their opinion, met the basic criterion described above. One therapist made information regarding the study available to all her clients and two individuals who saw themselves as having made significant progress in therapy referred themselves.

At the time of the interview, eight of the eleven participants were still in ongoing therapy, although two of those eight were working through issues related to termination. One participant had not been in ongoing therapy for more than 10 years. She had, however, maintained contact with her therapist and had seen her over the years on an occasional basis for assistance with specific issues, the most recent being flashbacks of being abused at a much younger age than she had previously remembered. One participant had terminated therapy approximately one year prior to participation in the study; she had contemplated further therapy related to marital issues but had taken no steps to re-engage in therapy at the time of the interview. The third participant not currently in therapy was a member of an ongoing support group to which one of the therapists belonged and not a client of any of the referring therapists.

The initial recruitment of participants resulted in contact from ten individuals, nine women and one man, ranging in age from 28 to 46. Those individuals had a wide range of abuse experiences in childhood (range in the number of perpetrators, range in the relationship of perpetrator to victim, range of ages at onset, range in the duration of abuse, and so on), a wide range of problems associated with their abuse in childhood, and a wide range of experiences with respect to counselling/therapy/treatment. As the data analysis progressed, it became apparent that saturation was being reached in most of the categories developed.

There were, however, several areas suggested from the initial literature review where information was lacking. One area related to the issue of gender differences in the experience of sexual abuse and the subsequent effects of that abuse on the individual which might have implications for the process of recovery. The analysis of the interview from the one male participant in the initial pool suggested the need to interview a second male survivor in order to test some hypotheses generated from that interview. The second area identified in the literature that had not been addressed by any of the participants related to difficulties with sexually compulsive behaviours. A request was made, therefore, to one of the referring therapists for referral of any male clients, particularly male clients who had experienced problems related to sexually compulsive behaviours. An eleventh participant was identified in that way. In the course of that interview, it became apparent that this individual saw his participation in various twelve-step programs as the most significant source of his recovery. It was, therefore, possible to compare his experience of the recovery process with that of individuals who saw their participation in therapy as central to their healing. Although other individuals had identified participation in various support or self-help groups as important, the initial interviews had not focused sufficiently on those experiences to make that comparison. No other significant issues were identified in the data analysis with respect to the particular focus chosen for this study, and sampling therefore ceased at that point.

Data Collection Methods

The appropriateness of different data collection methods is dependent, as Arnold (1982) puts it, "upon what the researcher wants to find out" (p. 52). If, for example, what is of interest is the patterning of social behavior in a group of people, then participant observation is probably the most appropriate strategy. Alternatively, if one is more interested in information about internal states or information about past events, then interviewing is a more appropriate strategy. Interviewing may also be a more appropriate strategy when practical considerations make observation difficult.

In terms of this study, the decision to gather information by interviewing adult survivors of childhood abuse was made for several reasons. One is that the client's perception of the recovery process and what has assisted in that process was of primary interest. Secondly, the nature of the therapy process makes observation of more macro-level processes difficult. Specifically, if one is interested in a process that may take place over the span of several years, there are practical advantages to interviewing.

There are, however, a number of issues related to interviewing and the use of interview data that need to be addressed. One concern often raised in the literature on research methods is the possibility of forgetting or "retrospective reconstructions" and the need to structure interviews in such a way as to facilitate as accurate recall as possible. The following are a list of strategies and techniques that have been recommended for facilitating recall: (a) pacing the interview, through the length of pauses, rate of speech, and use of "silent probes" to establish a thoughtful, deliberate mood (Gordon, 1980); (b) the use of nonscheduled interviews and broad, open-ended questions to allow informants "to follow natural paths of free association" (Gordon, 1980); (c) "reinstating" the environmental and personal context that existed at the time, by asking factual questions, and taking advantage of respondents' "tendency to structure information" (Geiselman et al., 1985; Gordon, 1980; Merton et al., 1956; Tagg, 1985); (d) recounting the information in a variety of orders or from a variety of perspectives (Geiselman et al., 1985); (e) use of verbal cues to assist retrospection, such as "looking back" or "thinking back" as well as establishing clearly whether the focus of the question is the original experience or one's current appraisal of that past experience and structuring the question to reflect that focus for example, through the use of past tense in questions (e.g. "what did you think about when..."), (Merton et al., 1956).

Whether such procedures address issues related to retrospective reconstruction is a matter of debate. However, the question of whether retrospective reconstruction is problematic is also a matter of debate that depends on one's philosophical orientation. The purpose of this study was to investigate participants' understanding of the recovery process from the point of view of participants who had experienced recovery. What was of interest was the understanding that participants had, at present, of the process they underwent. In other words, what was of interest was the retrospective reconstructions of participants. The procedures described above, however, are also helpful in generating the kind of detail that allows the researcher to construct an understanding of the process that is being described as well and were, therefore, used for that purpose.

Spradley (1979) also suggests a number of strategies to obtain as dense an account as possible from informants. The first is beginning with "grand tour" questions which are broad, open-ended questions designed to elicit a description of significant information in the view of the informant and the second is to ask for examples. He further suggests that expanding the length of a question tends to expand the length of the response.

The question of the extent to which the interview should be structured is one that appears throughout the literature on interviewing. In terms of grounded theory studies, May (1989) suggests that early interviews should be on the less structured end of the continuum in order to allow informants to structure the information, but that later interviews may become more focused as the researcher seeks to fill gaps in the data and to test emerging hypotheses. May notes, however, the need to balance flexibility and consistency and notes that some consistency is essential in types of questions asked, depth of detail, and the amount of exploration versus confirmation covered in an interview in order for conclusions to be drawn. McCracken (1988) also speaks to the need to have sufficient consistency in interviews that comparisons can be made and recommends that "questionnaires" be constructed with "grand tour" questions and suggested prompts. In general, focused or semi-structured interviews, organized around areas of particular interest, appear to provide a balance between consistency and flexibility in scope and depth.

For purposes of this study, an interview guide was constructed based on the principles elucidated above (see Appendix C) in order to ensure some consistency in the information gathered. In general, however, an attempt was made to ensure that initial questions were as general and open-ended as possible so that the information provided would be structured by the participants' understanding of their experiences rather than by the researcher's questions.

The conclusions drawn in this study are based on intensive interviews with ten individuals. An interview with an eleventh participant was reserved for the purpose of evaluating the adequacy of the theory that was developed. Interviews were conducted between March 1992 and June 1993 and were between one and half and two hours in length. Interviews were taped, and verbatim transcripts of the interviews were prepared. Transcripts were, except in the case of the last interview, then forwarded to the interviewee for review and comment. That process resulted in follow-up with four of the individuals interviewed, two of whom found that the interviews had triggered some unexpected reactions for them. Contact from the third individual involved a request from her for a copy of the taped interview, and contact from the fourth interviewee involved a correction regarding a reference she had made in the interview.

Data Analysis

The process of data analysis in a grounded theory study is primarily an inductive one, that is, from "specific, raw units of information" to "subsuming categories." According to Lincoln and Guba (1985), there are two essential subprocesses involved in naturalistic inquiry, "unitizing" and "categorizing." Unitizing is a process of descriptive coding and a means of "fracturing" the data to use a term from Glaser (1978).

Lincoln and Guba suggest that a unit should be the smallest piece of information about something that can stand by itself, that is, "it must be interpretable in the absence of any additional information other than a broad understanding of the context in which the inquiry is carried out" (p. 345). The aim at this level is to generate codes that describe the data. Codes at this level are termed "substantive" or "in vivo" where the informants own words are used in the code. Initially, the strategy is to code each unit in as many ways as applicable, an approach termed "open coding" (Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990). As substantive coding progresses and the researcher compares units of data with each other, initial categories begin to form.

The data that the researcher collects, that is, the information provided by participants in the study, are "indicators of a concept the analyst derives from them, at first provisionally, but later with more certainty" (p. 25, Strauss, 1987). By making comparisons of indicator to indicator, the researcher is "forced into confronting similarities, differences, and degrees of consistency of meaning among indicators," (p. 25), and, in so doing, categories begin to emerge.

Lincoln and Guba (1985) see this process of "categorization" as one of sorting units into provisional categories on the basis of "look-alike characteristics" which may, initially, only tacitly be understood. As more and more units are categorized, the researcher begins to develop propositional statements or "rules" that can serve as the basis for inclusion/exclusion decisions. Those "rules" are then recorded in "theoretical memos." At this point, a shift from comparison of indicator with indicator to comparison of indicator with category occurs, and the researcher endeavors, through theoretical sampling, to "flesh out" categories (identify the properties of the category), to clear up anomalies or conflicts, and, generally, to extend the range of information.

As categories begin to saturate, the process of comparing category with category and developing "theoretical" or "analytic" codes to describe the relationships among categories begins. Descriptions of those relationships (or hypotheses about possible relationships) are also included in theoretical memos. Glaser (1978) describes a number of "coding families" useful in the generation of theoretical codes. The most often-referred to in general descriptions of the grounded theory method are "the six C's": causes, contexts, contingencies, consequences, covariances, and conditions. Other coding families which Glaser describes include those related to process (e.g. stages, phases, steps), to degree, to cutting points (e.g. critical junctures, turning points), to dimensions, or to strategies or tactics.

Spradley (1979), in discussing the analysis of ethnographic interviews, suggests a number of "semantic relationships" that can also usefully be used as theoretical codes. Those are:

- strict inclusion (X is a kind of Y)
- spatial (X is a place in Y, X is part of Y)
- cause-effect (X is a result of Y, X is a cause of Y)
- rationale (X is a reason for doing Y)
- location for action (X is a place for doing Y)
- function (X is used for Y)
- means-end (X is a way to do Y)
- sequence (X is a step or stage in Y)
- attribution (x is an attribute or characteristic of Y).

Visual displays (e.g. charts, matrices) and diagrams are also recommended in the literature as aids in identifying relationships (Corbin, 1986; Miles & Huberman, 1984; Strauss, 1987).

Strauss & Corbin (1990) call the process of identifying relationships between categories "axial coding." Axial coding is described as "a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This is done by utilizing a coding paradigm involving conditions, context, action/interactional strategies and consequences" (p. 96). For any given phenomenon identified in the study, the following are identified: causal conditions, context, intervening conditions, strategies, and consequences. Causal conditions lead to the occurrence of development of the phenomenon; context refers to the particular set of conditions in which strategies are taken; and intervening conditions "facilitate or constrain the strategies taken within a specific context"

(p. 96). Strategies are purposeful actions which are directed at "managing, handling, carrying out, responding to a phenomenon" (p. 104). They are, in Strauss & Corbin's terms, "processual;" that is, strategies can be analyzed in terms of sequences or change over time. Consequences are the results or outcome of strategies taken; consequences may also become the context or conditions related to some other identified phenomenon.

In general, this process of describing relationships between categories is a process of linking categories which serves to integrate the data. One further step in this process is the identification of a "core category." A core category is defined by Glaser (1978) as one that "accounts for most of the variation in a pattern of behavior" (p. 93). Glaser identifies a number of criteria for a core category including the following: (a) it must be central, that is, related to as many other categories as possible; (b) it must occur frequently in the data; (c) it is highly variable in terms of degree, dimension, or type; that is, conditions vary it easily; and (d) it has clear implications for formal theory. In addition to serving as a focal point for the emerging theory, integrating the theory around the core variable also delimits the theory, as only those categories that are related to the core category will be included in the theory.

The process of identifying relationships is central to the generation of theory. It is important to remember, however, that such a process is always an act of construction on the part of the researcher. The testing of those hypothesized relationships against the data is a crucial step in ensuring that one's theory remains grounded.

While mention has been made of theoretical memos, it is perhaps important to elucidate the various functions performed by theoretical memos. Theoretical memos are of different types and serve different functions throughout the research process. In her description of memo development, Corbin (1986) illustrates different kinds of memos. At the initial stage where the focus is on generating categories, "category memos" may describe an emerging category. At the stage of building and "densifying" categories, one might have a "comparative memo" or a "memo of degree." At the stage of linking categories, "hypothesizing memos" might be used to develop an hypothesis about the relationship between two categories. At the stage of identifying the core category, the memo might be an attempt to relate a number of categories.

Rennie, Phillips, and Quartaro (1988) provide a very clear description of the various functions that memos have:

> [Memos] help the analyst to obtain insight into tacit, guiding assumptions. They raise the conceptual level of the research by encouraging the analyst to think beyond single incidents to themes and patterns in the data. They capture speculations about the properties of categories, or relationships among categories, or possible criteria for the selection of further data sources. They enable the researcher to preserve ideas that have potential value which may be premature. They are useful if gaps in the relation of theory to data arise, for they provide a record of the researcher's ideas about the analysis and can be used to trace the development of a category. They are used to note thoughts about the similarity of the emerging theory to established theories or concepts. Finally..., they play a key role in the write-up of the theory. (p. 144).

Memos are, in sum, the researcher's analytic record and play an important role, not only in the development of the theory, but also in ensuring that an audit of the process is possible.

The analysis of data in this study was facilitated by the use of a hierarchical outline computer program. Interviews were typed into the program and each ideational unit was assigned a number. Those units were then coded and grouped into categories. Relationships between categories were analyzed using the coding paradigm described by Strauss and Corbin (1990) as the major system of analysis.

Focusing on conditions and consequences was particularly useful in delineating the stages of the process, the recursive nature of the process, and the relative importance of particular therapist behaviours at different points in the process. Focusing on the strategies employed by participants allowed the researcher to appreciate the extent to which client behaviours, rather than therapist behaviours, are the central element in change. The identification of risk-taking as a core category then became central in the more theoretical exploration of change which involved the integration of ideas generated by this study with literature on human change processes.

The use of an outline program allows the researcher to retrieve, easily, specific statements by participants that illustrate more general ideas. In order to allow the reader the most direct access to the data on which the model of the recovery process was developed, a decision was made to quote liberally from the interviews. It is my hope that other survivors will find that information useful. To that end, an attempt was made to avoid language that might interfere with the readability of the results section. With respect to the scholarly community, one of the impediments to the use of new methods in a field, in my opinion, is a particular style of language that appears to be jargonistic. For those reasons, some of the terminology often seen in the reports of research conducted using the grounded theory method are absent.

The Evaluation of Qualitative Studies

Lincoln and Guba (1985) argue that conventional reliability and validity criteria used in the evaluation of research studies are often inappropriate in the context of naturalistic inquiry. They suggest a number of alternate criteria in the evaluation of such studies, specifically, (a) credibility, (b) transferability, (c) dependability, and (d) confirmability.

In terms of credibility, Lincoln and Guba (1985) argue that studies should be carried out in such a fashion that the probability that the findings will be found credible to the informants and others who are the focus of the study is enhanced. Particular strategies recommended in that regard are "prolonged engagement" to build trust and minimize distortions and the use of "triangulation" which refers to the use of multiple, different sources, methods, or investigators. Peer debriefing is further recommended as a strategy for keeping the researcher "honest" by providing an opportunity for biases to be probed and interpretations clarified. Lincoln and Guba also suggest "reserving" some data, that is, not using it in the development of the theory but retaining it to test the adequacy of the theory developed. Finally, "member checks," that is, obtaining input from informants or others to whom the study applies about credibility, are recommended.

With regard to issue of transferability, Lincoln and Guba (1985) argue that, while the external validity of an inquiry developed using theoretical sampling cannot be specified, the researcher can and should provide sufficient description about the context in which conclusions are developed (e.g. who the informants were, how data were collected, and the situation(s) in which data were obtained) that other researchers will be able to judge the extent to which the results are "transferable" to another context. In general terms, Chenitz and Swanson (1986) argue that the greater the internal variation in the sample, the more generalizable the results.

Lincoln and Guba's major recommendation with regard to "dependability" and "confirmability" is an inquiry audit. In addressing the process of the inquiry, the audit speaks to the issue of dependability; in addressing the product of the inquiry, the confirmability of the study. Whether or not an audit is actually carried out, Lincoln and Guba recommend that there be a clear "audit trail," or, in other words, records that permit an audit to be done. Categories of records for that purpose include: (a) raw data (e.g. audiotapes, transcripts), (b) "data reduction and analysis products" (e.g., unitized information, theoretical memos), (c) "data reconstruction and synthesis products" (e.g. theoretical memos about categories, relationships, and so on, as well as the final report), (d) "process notes" (e.g. theoretical memos re: sampling), (e) "materials relating to intentions and dispositions" (e.g. research proposal, personal notes), and (f) instrument development information (e.g. pilot forms, interview guides).

Athens (1984) also speaks to the issue of the credibility of qualitative studies and argues that the adequacy of a research account is given by the presence or absence of a sufficient description of three matters: (a) the means by which the researcher "gained entree" to the persons or groups studied and how that was maintained or increased over the course of the study, (b) the means by which the researcher gathered the data (e.g. the nature of open-ended questions that were asked, probes that were used, general circumstances under which interviews were conducted), and (c) the means by which the researcher analyzed the data so as to produce the results reported in the study. Again, the emphasis is on providing the kind of information that would allow others to assess the process by which conclusions were developed.

Athens (1984) also discusses two other criteria that should be considered in the evaluation of qualitative studies, namely, theoretical import and empirical grounding. The latter refers to the extent to which concepts are linked to the data from which they were developed, and Athens recommends that each major concept presented in the study be accompanied by some description of the empirical data which led to its development. With regard to the issue of theoretical import, Athens sees the contribution which the study makes toward the development of new concepts or theories or the refinement and further development of existing ones as the most important factor upon which a qualitative study can be judged. Qualitative studies, no less than quantitative studies, should add to a field of study in such a way as to lead to the building of a coherent body of knowledge in that field.

Several procedures were used in this study to ensure its credibility. Interviews were lengthy in order to provide time for the establishment of rapport, and opportunities were provided for follow-up contact. Description of the study results made extensive use of quotations from interviews to illustrate concepts. One interview was reserved and analyzed after the theoretical framework for describing the process of recovery was developed. Finally, input was received from other survivors, not interviewed for the study, regarding its credibility.

With respect to other evaluative criteria, attempts have been made in this chapter to describe the participants and data collection procedures in sufficient detail that the extent to which results can be generalized to others can be assessed. Records that would permit an audit of this research have also been maintained, although no audit has been done. Memos were used to record information related to the research process, for example, reflections at various decision points in the process and identification of personal beliefs that might influence the interpretation of data, as is suggested in some of the literature on qualitative methods.

While some qualitative studies attempt to identify potential sources of personal bias in the research report, a decision was made not to do so in this case for several reasons. One is simply a strong belief that all researchers, whether they employ quantitative or qualitative methods, influence the results of their research in ways that may, or may not, be identifiable to the researcher. That influence can occur at various stages of the research process, for example, in the focus of the research, in the particular questions that are asked or not asked, in the interpretation of results, and so on.

While the credibility of the research and the degree to which conclusions follow from data can be evaluated, the researcher's beliefs and assumptions are always embedded in the results of his or her research. The suggestion that identifying one's biases (assuming that it is even possible to do so in a comprehensive fashion) implies that it is possible to identify salient features of the screen behind which "reality" can be discerned. With respect to any particular research project, however, it is difficult to identify what those salient features might be. A preferable strategy is simply to acknowledge that all human science research is, in a sense, the construction of the researcher, based on his or her interactions with the participants in the research, and to focus, not on the extent to which the results represent "reality," but on the extent to which the research is credible, in Lincoln and Guba's (1985) sense of the word, and the degree to which it extends our understanding.

Ethical Considerations

Ethical issues were handled in accordance with the guidelines established by the University of Alberta and with the Canadian Code of Ethics for Psychologists (1991).

All participants were fully informed of the purpose and procedures of the study, potential risks and benefits, and their rights as voluntary participants, including the right to withdraw from the study at any point, to terminate an interview, or to decline answering any question of the interviewer. All participants were asked to sign a consent form (Appendix D) and did so.

In order to ensure the anonymity of the data collected, the following steps were taken. Participants were never identified by their full name on the audiotape of the interview and were given a participant number and pseudonym on the transcript of the interview. Attempts were made to ensure that any identifying information was excluded from this final report. A separate list of participant names, address and telephone numbers, participant numbers, and pseudonyms was kept in a secure location as were the audiotapes. The tapes will be erased upon completion of the study and the list referred to above will be destroyed.

It was not anticipated that the interview would result in any significant distress for participants as the focus was on positive changes made in the course of recovery rather than details about the abuse experienced by participants as children. Furthermore, the open-ended nature of the interviews was seen as offering participants considerable control over what they wished to disclose. All participants were advised, however, that referral to an appropriate services would be provided, if needed. Most of the participants had an ongoing relationship with a therapist at the time of the study. All of the participants had identifiable support networks which they actively used when abuse issues surfaced.

Despite those safeguards, it is worthy of mention that at least several of the participants needed to address issues that arose for them during the interview. Those issues involved recognizing the continuing impact that the abuse had, identifying unresolved issues, and, thirdly, the impact of talking in depth about the recovery process to someone other than one's therapist.

In two cases, participants addressed those issues with their therapist and were encouraged to contact me so that I was aware of the impact that the interviews had for those individuals. In another case, I became aware of those issues following contact with one of the participants who requested a copy of the audiotape of the interview as well as a copy of the transcript. It was not necessary to make referrals for any of the participants given the existence of supportive others in their lives whom they actively used. However, the experience of some of the participants in this study clearly identifies the need for precautions to be taken in interviewing individuals about issues that have the potential to generate emotional reactions.

Chapter IV
Results

The focus of this chapter is the process of recovery or healing from the negative effects of childhood sexual abuse as described by ten of the eleven individuals who participated in this study. Particular emphasis is given to the role of therapy in that process, specifically, attitudes and behaviours of therapists that can help or hinder that process.

The Beginning of the Process: Wanting Change

For all of the participants in the study, the process of recovery began with some desire for change. Two different conditions served as an impetus to seek help: (a) a state of crisis which the individual was seeking to control, and (b) the desire to change a long-standing patterns which were increasingly seen as a source of pain.

Condition One: State of Crisis

In the first condition, the individual was in a state of crisis. That crisis tended to be precipitated by some external event, in combination with the failure of past coping behaviours to control one's level of internal distress or emotional pain. Participants sometimes described that point as "hitting bottom" or "recognizing that something has to change." In this study, the events that precipitated a state of crisis were the loss or threatened loss of a relationship or some other situation where the dynamics triggered memories of the abuse.

Diane, for example, was hospitalized after attempting suicide following the end of what she described as a very destructive relationship. "I had almost literally reached rock bottom," she says of that time. "I had nowhere to go but up any more. I was feeling so suicidal and just like I had nothing and was nothing."

Fiona, similarily, talked about "hitting bottom" following the death of her grandfather:

> My grandfather died just two years before I came into recovery--a year or two years--and that was the beginning of the end of a lot of things. I got severely depressed after he died. I didn't leave the house for months, didn't do drugs, didn't drink. I started writing this book called "Theories of a Potential Suicide." I wanted to die; I was so depressed....I think that in a lot of ways I was really in love with him--in love with my grandpa. I loved the attention that I got from him even though it was totally inappropriate. I didn't recognize that; it was attention....When he wasn't there any more, a lot of things that I was getting from him [weren't] there any more, and because I got so down and depressed, I think that sort of helped me hit my bottom....When I started drinking again, I could really see how--the alcoholism had really progressed. I never knew when I'd be drunk. I'd be drunk on a couple of draft or I could drink a mickey and plus of gin and not feel a thing....I had a real hard time accepting that I'm an alcoholic; that was hard. I didn't want to be an alcoholic; I didn't want to give up my booze.

For Fiona, alcohol and drugs were important aids in coping with having being abused as a child. The substances kept her, she says, "in a place where I didn't have to deal with a lot of stuff" partly because they helped deaden her emotions and partly because the lifestyle associated with her drug and alcohol use didn't leave her much time alone. When she began treatment for her alcoholism, the memories of her abuse began to surface, and the state of crisis generated by the feelings associated with those memories became an impetus to seek further help.

Fear of losing a significant relationship can also serve as an impetus to seek help, perhaps because, like the actual loss of a relationship, it triggers fears of abandonment experienced as a child. For George, an incident at a family reunion, where he experienced the fear that he was risking the loss of significant relationships in his life, was a crisis point that led to his decision to seek help:

> I went to a family reunion, and I was with my mom and my sisters and my wife, and I just lost it. I was like a 14 year old kid again, just in a fit of rage, yelling and screaming...I was reacting to some control stuff with my mom, and I used anger--one of my favourite ways of avoiding control--and my wife left with my kids and, for me, that was a bottom--something had to change. [What made it a bottom] was, for me, the idea of losing my wife. At some level, even really unconsciously, I knew that my wife loved me--as much as I know what love is--and I was about to lose that...

Situations in which the dynamics parallel the abuse experienced as a child in some way may precipitate a crisis. Merry, for example, found herself in a situation where feelings associated with her abuse were being triggered. In addition, she experienced the lack of support which she had expected from her female associates as a replication of the lack of support she experienced from her mother during the time her father was sexually abusing her:

> I started working at ***, and within that context, I was turned on by other women. Other women turned on me, and I have consistently felt that from my mother. I think it just [triggered all of the feelings connected to my mother]....I'm pretty sure that's what brought it all up.

Merry had no conscious memories of her abuse at the time, but she says, "I was subconsciously, I'm convinced, looking for a way to bring them out because I kept reading books to do with the issue." From her description, it seems likely that she was also experiencing feelings associated with her abuse. Merry describes feeling "awful, and it was like almost moving into everyone was out to get me...I didn't feel safe. I was totally unfocused. I would sit at my desk at work, and I couldn't, couldn't do anything." She found the situation at work very stressful and said, "I just knew if I didn't see somebody...something horrible would happen, or I would just stay stuck. I felt stuck and unable to cope."

Re-experiencing aspects of childhood trauma is not uncommon among survivors; all of the participants in this study reported instances where some aspect of their abuse as a child would be re-experienced in the present. When that occurs in an uncontrolled, fragmented way, individuals often believe that they are "going crazy" because they have no other framework for understanding what is happening. Such experiences may, in themselves, create a state of crisis that leads an individual to seek help, as was the case for Stephen:

> ...[it felt like the] top of my head was coming off. It was just all of this stuff that I had managed--the boxes that I had managed to keep closed for so long wouldn't stay closed any more, and it was too much for me to handle. I was going crazy. Literally. Inadvertent thoughts that would come in the night and in the middle of the day. I would go from feeling great to just wanting to jump off a bridge over nothing that happened through the day--just what was going on in my head with the thoughts, memories, call them what you want. They were starting to run unchecked through my head.

When Diane's memories of being abused as a child began to surface, she, also, experienced the fear that perhaps she was going crazy:

> It was around February or March I started getting memories. Little flashbacks and body memories and smells. Hearing things in my head that weren't related. Things that people said or noises that were associated with the abuse, but they weren't connected to anything today. I don't know if you know what body memories are like--it's like your body has a memory of its own--and ways that I had been touched that were really abusive, I

> would start feeling the sensation of being touched when there was nothing there....I basically fell apart....I stopped sleeping, eating--just basically became a zombie for about four months....I contacted the Sexual Assault Centre and was seeing somebody there, and she kept reassuring me that what I was going through was normal."

In all of these situations, the primary motive is control, that is, to control what is surfacing, to stop the pain. The abuse may be identified as the source of pain, as it was in Stephen's case, for example, or it may still be outside the individual's conscious awareness.

Condition Two: Desire to Change Long-Standing Patterns

In contrast are the individuals who are motivated by a desire to change long-standing patterns that are increasingly seen as a source of pain. This is not to say that a state of crisis may not emerge in the process of therapy. However, the individual is not in a state of crisis at the point of entering therapy. Rather, the desire for change and the search for help is related to a sense that something inexplicable is wrong in one's life. In some cases, there is no conscious knowledge of one's abuse at the point of seeking help; in other cases, conscious memories of the abuse do exist on some level, although they are often devoid of any emotional content. In both cases, the impetus for therapy is usually something other than the abuse itself.

Elizabeth, for example, began therapy because of a weight problem and a vague sense that something wasn't right. "I knew there was a reason why I was fat, and I didn't know why," she said in the interview. Colleen, similarily, talked about her general unhappiness and sense that something had happened to her as a child that kept her from being happy:

> I started seeing Fern [therapist] about four years ago. I had been having dreams and a lot of problems in my life, feeling that I was--that I had a lot of sort of false personas. That I couldn't really relate to people;

> that there [were] a lot of barriers between me and other people, and I was really questioning who I was and feeling very strange about things, and it was really affecting my other relationships....I had started to have memories come back but just little tiny fragments of things. I knew that when I was nine that I had had some kind of breakdown or something...I had gone catatonic one day. And I didn't have a reason for that....my mother...had said that there had been a lot of pressure on me at school from a teacher, that this was a stress reaction...so I did have that memory...I knew something had happened. But I started--it's hard to pinpoint exactly what took me to therapy. A part of it was the relationship I was in--my husband. I was starting to question who he was; it was like waking up with a stranger a lot of times. And I began to question who I was in relation to him.

Later in the interview, when talking about an intervention made by her therapist, she talked more about what had motivated her to seek therapy:

> ...one of the major things that brought me to therapy was that I was feeling very flat emotionally and that I had--I couldn't cry any more--about anything. I never cried any more. And I was really getting worried about that, really concerned...I mean why? I knew I was feeling things very deeply--why couldn't I express things? Why had I built up all these walls that I couldn't tell people that I loved them, that I couldn't cry over things, that I couldn't ever make myself vulnerable enough to do that. I had to be tough all the time.

Some participants did have conscious memories of their abuse but entered therapy for other reasons, not necessarily making any connection between their abuse in childhood and current problems. Helene, for example, began therapy because her marriage was "not very good," and she was unhappy in that relationship.

Others began therapy because they believed that there was a connection between their experiences in childhood and problems in the present that needed to be explored. Often there will be some experience that causes the individual to consider that possibility. George, for example, first began to make some connection between growing up in an alcoholic, abusive home and his own alcoholism: "I saw this Bradshaw guy on TV and I, all of a sudden, became aware that the way I was brought up maybe had something to do with what was going on with me." In the process of looking at his alcoholism, George found himself forced to confront what he considers a sexual addiction as well and to begin the process of understanding the impact of his parents' inappropriate and abusive sexual behaviours.

In summary, individuals entering therapy may differ in terms of whether there is conscious awareness of being sexually abused in childhood and in terms of the extent to which they are in a state of crisis. Regardless of those differences, however, what prompts the search for a therapist is a desire for change.

Searching for a Context to Support Change

All of the individuals in this study talked about their search for an environment safe enough to reveal themselves and explore the impact of being sexually abused in childhood, or, for a context that would support change. There was, however, considerable variation in the nature of that process. In some cases, participants were only, in retrospect, able to identify their actions as a search for a context that would support change; that is, there was no conscious motivation to seek such an environment. Heather, for example, describes her involvement with a sexual assault centre in that way:

> I was drawn to doing work at the sexual assault centre...I was working as an editor of a lesbian

> newsletter and the sexual assault centre was offering a lesbian incest survivors' group, and I was curious...I had known for a while that I was a survivor, but there was no affect involved. It was just very abstract knowing. So I did an interview with a woman for the newsletter - the woman who was running the group - and then decided I wanted to do work at the sexual assault centre, somehow knowing that would be my context for my relationship to this. I went to one session of the training program and sort of fell apart and decided that, in fact, that's not where I want to be going, but that was sort of a larger pretext for a connection...that I didn't understand until after I tried that. Up until that point I still had no sense of any emotional connection to what I knew was abuse...it's been very recent that a lot of the emotional stuff has surfaced for me. So I have been working to try and open that up, I guess, in hindsight.

In other cases, the search for a context that would support change was clearly conscious, although not directed by any sense of particular factors that were important in that regard. Colleen, for example, simply saw the first person available at the counselling agency where she sought help:

> I remember her [therapist] asking me...she asked me how I heard of her, and I said that I really hadn't [laughter]. I had just come to [the agency] and it was just a fluke that I saw Fern [therapist].

For others, the search was a purposeful one for a therapist who met one or more of a number of criteria important to the individual, e.g. a therapist who was knowledgeable about issues related to sexual abuse or a particular problem area such as substance abuse or compulsive eating, a therapist who was accepting of gay or lesbian lifestyles, a therapist who was seen as trustworthy or likable, and so on. Strategies employed in the identification of potential therapists included both referrals from others and assessment of the therapist in other contexts. Helene, for example, after one negative experience with a counsellor, decided that she needed to feel comfortable with a therapist to make any progress in therapy:

> I was in an honour's program with Jill's [therapist's] cousin, and Jill's cousin mentioned her to me, and I said, "Well, I'm not seeing anybody until I meet them personally and know whether I like them," realizing that, if you don't like your therapist, you are not going to get very far. And I didn't like this woman that I had first seen. So I met her [Jill] socially, and liked her, so I thought I would give her a try.

For Heather, when she began her search for a therapist outside the context of the sexual assault centre where she had volunteered, that sense of personal compatibility was also important, but, for her, there were a number of other issues as well, including knowledge about the effects of sexual abuse and acceptance of a lesbian lifestyle:

> I had been in Edmonton for a long time. I moved away from here and went to Toronto for a year, and at the time, just before I left--I guess for a year before I left--I was involved with a woman whose little girl disclosed sexual abuse and there was a long court hearing--a court battle, basically, involving the child's father--because it was--the child disclosed that it was the father who was abusing her, but, at the same time he ended up suing for custody based on the fact that we were lesbians....Jill was brought in to do an assessment of Mary [the child]...based on what I saw of Jill--I mean, Jill really went to bat for us in the case and [I] saw her as a real advocate of children who were being sexually abused, and so I felt instantly a connection with her and thought, "This is somebody who feels safe." ...plus she knew that this was a lesbian custody issue as

> well and she was willing to go to bat for us and protect Mary at the same time. It felt very clean, you know, it was free of complications from her. So she came across as quite safe ... When I decided to come back to Edmonton, I wrote her a letter and said, "Can you put me on your waiting list?"

The extent to which individuals had predetermined criteria for potential therapists depended on a number of factors. Many of the participants in the study had seen previous therapists who had not been helpful, and they were, therefore, inclined to seek referrals from others or to choose individuals they had met in other contexts as therapists rather than trusting to luck. In some cases, past experiences also influenced the nature of the help which an individual would consider. George, for example, had no interest in working with a psychiatrist as a result of his experience with a psychiatrist as a child:

> I became the designated patient...in my family, and I was sent off to a psychiatrist when I was in Grade 4. I can remember I used to leave school early, and I used to walk down to the--my mother didn't drive--so I used to leave school early and walk down--about six blocks down--to the bus, take the bus to downtown...go to my little shrink, sit there all day, and take the bus home...I have a lot of sadness around that and a lot of anger around psychiatrists --I wouldn't do this for a psychiatrist--basically I have a lot of rage still I haven't dealt with [because he didn't look for a reason for what was happening].

To some extent, the caution exercised in choosing a therapist was also related to the degree to which the individual was generally cautious in entering relationships with others. In most cases, however, the individual's knowledge of the range of helping resources and his or her financial wherewithal were major factors in the search for help. Situational factors also influenced the nature of the search process in some cases. For example, Diane's hospitalization following a suicide attempt put her in contact with resources to which she might not otherwise have had access.

For some, the process of finding help was a long one, marked by contact with mental health professionals that was sometimes not merely unhelpful, but harmful. Diane, for example, indicated that, over the years, she saw multiple therapists for varying periods of time. One of her interests in participating in the study was her hope that sharing her experience would help therapists become more knowledgeable and more sensitive to the needs of survivors. In her own words:

> I am glad to be able to take part in something like this because there have been a lot of things that I have been through that I could have done without, quite happily, and, ideally, should never have happened. Part of it was out of ignorance and part of it was that the therapist sometimes was just as unhealthy as I was.

The degree to which individuals persevered in their search for help, whether that be the search for a therapist with whom to work, the search for a healing community, or the search for information or experiences that would help the healing process is a testimony to the strength of the individuals in this study. In addition to the emotional pain to which one opens oneself as part of the healing process, many individuals face other obstacles that have to be overcome as well.

Those obstacles may include negative experiences with mental health professionals; they may include limited knowledge of the scant resources that do exist; they may include a lack of financial resources that further limits options regarding sources of help. Obstacles may also include lack of support, or positive discouragement, from significant others.

In situation after situation, individuals in the study talked about attempts from family members to keep them from exploring the past or to keep them from making changes. In some cases, explicit messages were received from family members about the use of helping resources. Marianne's father, for example, expressed the belief that seeing a therapist was a clear sign of one's individual deficiencies as a person. For her to even seek help from a therapist meant that she needed to find the internal strength to take a step that opposed the world view of the man whose views had been the basis of her family's reality.

For others, significant pressures to maintain silence about the abuse were exerted by family members. Fiona, for example, described some very blatant attempts by her family to silence her that escalated in response to her determination to have her family acknowledge the abuse:

> I brought up the abuse to [my mother], and she said she didn't know because she didn't remember. She said she was going to get some help, and then she came back a month or so later and said, "It never happened; I couldn't do something like that."...after a period of time...she said...she did have a memory. She remembered a couple of things; she validated two incidents...but she totally minimized it. "It was curiosity; she stopped when she saw it was hurting me," and she totally changed it....I kept bringing it up...apparently every time I would bring it up, she would get upset and then her husband would get upset...She said to me at one point when I brought up the abuse again because I...wanted to be heard, and I wanted to hear the truth, not some pretty version of it she could live with...At that point they were putting me through school fully and they had given each of us kids $50,000 in stocks and bonds, and then she said, "Every time you upset me and you bring up this abuse, [husband] wants to cut you off the money." And I

> just went, "Fine. I don't want any more money, and you can take your $50,000 back." Well, actually, it took me about a week to say it--I never had so much money in my life--probably never will. Anyway, I told them I didn't want the money because I didn't want that kind of control on me, and I didn't want somebody telling me what I could say and couldn't say. Then I, shortly after that, decided I was going to cut it off because I needed the space, I needed the time, and I just knew that. I don't know if I would have had the courage to do it so much, but when I decided that I wasn't going to see her any more, she called me up and she told me that I had better keep my mouth shut about the abuse, and she was going to sue me for slander--that if I was serious, I had better charge her or shut up, that it was her family not mine, and if I knew what was good for me, I wouldn't be talking to them any more about it either.

The strategies for survival that individuals have adopted may also serve as obstacles to seeking help. Adoption of the role of caregiver, for example, may inhibit the search for help for oneself or may lead one to meet one's needs for help in indirect ways that do not address the root of the problem. Heather's description of her involvement with a sexual assault centre as a "transition" illustrates the way in which one's history has the potential to impede, at least for the time, the search for help:

> In some ways, I think the work I did at the centre was a reproduction of my family and yet the flip side of that was really wanting to either be taken care of or have a space where I could talk about my things...but the role, the roles that I entered into there were as a caregiver. I think I wasn't ready yet to walk away from that. That role had been with me for a long, long, long time and had been the only way I really knew how to be in the world. I think at some point I had to make a shift and the

> centre was a place where that could happen. There could be some crossover in the sense that it was safe, that I could have some feeling there. I was "out" as a survivor, I received counselling there, but my role was still to take care of other people, so it was safe. It was a safe transition in some ways.

For Heather, it *was* a transition, and she was able to move into a therapeutic situation where she did not need to continue to be a caregiver for others. Given a different set of circumstances, that step may not have occurred.

In listening to the stories of the individuals who participated in the study, two factors seem important in whether or not a person finds help. One is the degree of perseverance; the other is quite simply luck. Someone, at some time, makes a difference and fosters the hope that change is possible and the search for help worthwhile.

For Diane that contact came from a therapist at the hospital following a suicide attempt. In talking about the day hospital program, she says:

> I was feeling so suicidal and just like I had nothing and was nothing, and partly what it did was give me some hope back that maybe I was worth saving...the individual therapist I had, I could connect with. She seemed to understand me and like me, and she didn't judge me.

For Fiona, that glimmer of hope came from a woman at the first AA meeting she attended:

> ...all of those things were getting me to a point where I had to do something, one way or another. I either was going to kill myself, or I was going to give the program a shot....I heard somebody who had 14 years sobriety get up and talk about how she was having a really rough time, and she didn't know if she was going to be able to stay sober. All these terrible things were happening to her, but she was there at a meeting standing in front of all of these people with 14 years behind her sober talking

> about her fears and talking about her pain. That woman I will never forget. To me that was a sign of hope, because I think I was so afraid that I was--[I think] I had some idea of what I should be and I could never live up to that, and so to hear this woman stand up and say, "I am still vulnerable, I still have pain; my life is better, I have been sober for 14 years, but right now...." To me, that was such a potent message.

Others find hope in the discovery of a body of knowledge that suggests that there may be some answers to why they feel and think and act as they do in the present. George's comments about the impact of seeing Bradshaw on TV and recognizing that the alcoholism in his family might be related to his own problems with alcohol is one such example. Marianne's emerging awareness of her own abuse following her brother's disclosure and her reading about sexual abuse is another. For her, having some explanation for her "sick sex dreams" and for the ever present suicidal ideation gave her some hope that change was possible.

Elizabeth described the impetus for therapy using a carrot and stick metaphor, with the stick representing the pain one is experiencing and the carrot representing the positive gains that one anticipates, or recognizes, as therapy progresses. In the beginning, it is often difficult to envisage a different state. For many, the "carrot" is simply that spark of hope that there are others who care and that change is possible.

Making Connection: Developing a Sense of Safety in the Therapy Relationship

Abuse involves the destruction of that which is required for normal development and psychological growth, namely a sense of safety and security. For healing to occur, a sense of safety and security needs to be established. In both cases, those processes occur in an interpersonal context. Abusive relationships create a sense of fear and insecurity;

relationships based on caring and respect create a sense of safety and security. Part of healing involves the establishment of a connection with another who can be trusted to be understanding, respectful, and supportive.

Over and over, participants in the study talked about how important feeling accepted and cared about is, both in making the therapy relationship safe and in supporting the healing process. Diane, for example, talked about being able to connect with her therapist at the day hospital program because of her ability to communicate acceptance and caring:

> She seemed to understand me and like me, and she didn't judge me. She just had a very caring way of coming across...When I talked to her about the things that I had to talk about, I didn't feel that anything I said was rejected. I was never criticized for what I said, or, if I was angry about something, it was OK.

For Fiona, the feeling of being accepted and understood was crucial to making the therapy relationship safe enough that she could begin to talk and remember her past:

> When the little kid came out, she wouldn't laugh, and she would deal with the little kid. It became a place where I could--where the little kid could come out, and I could cry. I could cry and it was OK, and I began to be able to talk about stuff. I began to have more memories, and it just felt like a really safe place. It was like she instinctively knew how to respond to me, and she understood. I felt like I was understood, like she knew, and it was OK.

Part of communicating acceptance is not pushing individuals faster than they are ready to move. Stephen, for example, talked about the importance of the patience that he felt his therapist showed with him. Colleen, similarily, talked about the importance of her therapist's respect for timing:

> At the beginning there were a lot of barriers for me to trusting anybody, to talking about it. It was very, very difficult for me to say things that I knew. It would take me months to actually come out with things, and what was nice about working with Fern at the time was that she was very patient. She would push me in some ways. She would challenge me in some ways, but never to disclose things that were--she never pushed me beyond where I was ready to be.

In addition to making the therapy relationship safe, acceptance by one's therapist is, in itself, part of what enables healing to occur. As Diane suggests below, it may be the most important of all the things that a therapist may provide:

> I think that one of the best things that any counsellor can ever do for someone they are trying to treat is to accept them, give them as much acceptance as is healthy and as they need, because chances are they are there because they haven't had much. The most healing I have done has been with people who don't invalidate my feelings, where I can say this is how I feel about something, and I can feel that it's accepted, and I am not told why you shouldn't feel that way--or for the person to try and get me to change how I am feeling in some way--just to accept it. I am the only one who can change how I feel....What I need is just validation that "Yeah, I hear what you are feeling, and I understand it." That's a lot of what I needed, because I had been so invalidated.

A sense of caring is communicated by actions as well as words. Sometimes the actions that convey caring focus around the structure of therapy. Stephen, for example, talked about his therapist's willingness to accommodate his uncertain schedule and her flexibility in rescheduling appointments as important in conveying the message that she cared about him:

> She has organized her schedule to meet mine. I work; I chase rigs around. Today's meeting--I thought was today--was yesterday. I'm going back at four o'clock. She makes time for me.

Sometimes therapist actions that convey the message that the individual is cared about occur outside the context of the therapy session. Elizabeth, for example, talked about how important two such incidents were for her:

> There's kind of a place where I guess talk is cheap and your actions show it...Two really significant things for me were when I bought my new car, Jill came out of the [office] and wanted to see it, so it's like I mean more than just a case, it's like being interested in me outside of that session. As well...even though my father had been dead for a year, [it was] too scary [to confront him]...and she offered to come with me to the grave...I couldn't believe that she would take time to come with me to the grave so I could confront my father. That was really significant for me, too. So, again, I guess...these are also ways that she communicated things to me that built trust.

In terms of safety, what is important is that the actions and the verbal messages of the therapist are congruent. If a therapist verbalizes the belief that individuals are the best judges of what they need for their own healing, then it is important that the therapist's actions support that. Elizabeth, for example, talked about the ways in which her therapist showed that she really believed that Elizabeth was the best judge of what she needed at any given time:

> Lots of time [she'd give] homework, and it would be fine if I didn't do it, so sometimes I didn't bother, and that was OK, too....Another thing that I really like about our sessions is that she goes with where I am at that day. I don't have to pick up [from last time]. It's like, "Where are you right now?" Because I'm all over the

> place, and it can be very limiting if we have to finish everything.... [sooner or later I come back to what I need] in a natural kind of way.

A "safe place" means not only a place where one is accepted and understood and where one can trust that the other's actions will be in accord with his or her words. It also means a place where one will not be abused and where the dynamics associated with the abuse are not replicated. As Diane clearly indicated in her description of her experience in a group home, "more of the same" doesn't help:

> A lot of the therapists [I have seen]...tended to have the attitude that they knew what was best for me. I was feeling like I had so little control over anything and they were trying to take what little bit I had left--at least that's the way it felt--trying to tell me what to do, trying to give me advice and then expecting me to take it, sometimes getting angry when I didn't....Part of the problem with...the group home [was] their whole philosophy. For me, it was more of the same. I was looked after by my grandmother for eight years. She was a very domineering, overbearing, controlling person. The philosophy that they had in the group home was to break down the person's barriers and their personality and to build it back up again, but you had to do what they told you to do. I see that now as almost brainwashing. You [were] never allowed to be alone....Spending time alone was considered isolating and you were just not allowed to spend time alone....Something like that was just more of what I had grown up with--always being told what to think and what to do and never being able to think for myself, not being able to say this is what I like or don't like...

In contrast, Diane describes her experience with the therapist in the day hospital who gave her the hope that maybe she was "worth saving":

> I always felt that whatever I did, the choice was mine. She was just about the first person who had ever [trusted me to know what was best for me]....She didn't try to take care of me. I don't know if I can describe the difference between caring and taking care of--I only know when somebody is doing it. Really, what they are doing is taking your personal power away. In a sense, I felt like she was giving mine back to me.

One of the principal dynamics associated with childhood sexual abuse is a sense of powerlessness and lack of control associated with one's inability to stop the abuse. Taking the lead from one's client is one of the ways that a therapist can convey the message that the client has choices and that the client has the power to direct therapy in a way that meets his or her own needs. Many different actions can convey the message that the power to choose is in the hands of the individual seeking therapy. Colleen, for example, describes her first meeting with her therapist, an experience which, although uncomfortable, left her feeling that she had the power to choose her own course:

> The very first session that I went into with Fern, the major thing I remember about it, other than getting to know her a little bit and finding out about her approach, was that she wouldn't tell me when to leave. She didn't tell me when to leave, and so I sat there thinking, "Is this over? Should I go now? What should I do?" I actually had to get up and leave myself, under my own control, and there was no--there was absolutely no feeling of obligation to come back, and, at the same time...I knew that the door was very open. It was really scary at first. In retrospect, I can look back and I can see that made me--it really put the onus on me to come back. Basically, I wasn't working by somebody else's agenda, and so that was really nice.

Colleen's account is interesting because it shows the line that therapists sometimes have to walk in terms of providing sufficient structure to make the therapy relationship safe while communicating the message that the client's needs, not the therapist's expectations or desires, are to be the driving force of the therapy.

As Merry suggests in the following excerpt, it is also important to be aware that individuals who have been abused as children may have developed a pattern of acquiescing to authority in an attempt to protect themselves. As a result, it may be very easy to take power in the therapy relationship. There may also be situations where an individual, in fact, invites her therapist to do so:

> Initially I think I gave a lot of the power to Fern because I was feeling she knew more than I knew. I didn't have a clue about what was really happening, and I wasn't knowledgeable about theory and stuff like that...so I gave her the power, and I think her not taking it--I am sure that she realized that was what I was doing or that maybe that's the point I was at--and that even though I was vulnerable and literally crying out for assistance, there was never a point that she took it.

For individuals who become victims of sexual abuse at the hands of therapists, the damage can be extreme because the abuse replicates what was experienced in childhood and reinforces a myriad of negative beliefs about self and others. On the other hand, for some individuals, non-abusive physical contact can be important in conveying care and support. Fiona, for example, described a situation in therapy where she was re-experiencing the physical sensations of being abused as a baby and the importance of her therapist's physical response:

> There was one time where I was really little; I was so little; I was [just] a baby. I was having this memory,

> and I was being sexually abused, and I was really, really sore and hurting and crying, and I couldn't blow my nose, and my hands were moving like little kids' [hands]. I was just a little kid; I couldn't talk....Ann blew my nose for me, and she rubbed my back, and she just let me rock and just let me cry, and she didn't ask me too many questions.

Diane also talked about the need, at times, for someone to hold her when she cried and the sense of connection and the sense of being nurtured and supported that can be conveyed by that contact:

> A lot of times [what I needed] was just somebody to hold me when I cried. Sometimes the pain was just too intense for me to face by myself....For me, it was part of the healing, too, because I was almost never held when I cried. If I fell, I was just told, "Don't be so clumsy next time."

For Diane, however, it was also important that she be the one to initiate the contact. Part of that is related to the sense of being in control of the physical contact, in contrast to the situation as a child where one was not in control of the contact. The other part, as Diane clearly articulated, is that learning to be able to ask for what one needs is part of the healing process, too.

"Safe" is not an absolute construct; rather, it is a question of being "safe enough"--safe enough to reveal aspects of one's history that are seen as shameful, or safe enough to reveal behaviours or attributes of self that are disliked or that are a source of shame. "Safe" means being safe enough to focus on one's memories of being abused, knowing that one is not alone, believing that another can help one handle what one may never have felt capable of handling before. It means being safe enough to express feelings that may never have been directly expressed before. It means believing that abandonment or abuse will not be the consequence of allowing oneself to be vulnerable. It means being safe enough to take risks in the therapy situation to meet one's own needs. Above all, it means being safe enough to risk trusting.

Time and time again, participants talked about needing to have someone to trust in order to begin the process of healing. That trust is crucial, not only in terms of creating a context where the work necessary for healing can occur, but in terms of the healing process itself. The experience of having a relationship where trust is possible is often a new experience that opens the door to a realm of new possibilities. Stephen said, in describing the importance of developing trust:

> For one, it's something that I have never had. For me to trust someone in my life only meant one thing--that when I did, something was going to hurt somewhere.

The process of developing trust may take a considerable length of time. Often, it is one of the most difficult issues in therapy, as Colleen suggests in the following excerpt:

> The issue of trust was the big one for me in therapy. It took a long time for me to really trust Fern and that had absolutely nothing to do with what she was doing because what she was doing was making herself completely trustworthy all the time. She was there if I wanted to contact her virtually any time. All that I had to do was reach out....It was very hard just to take that offering and to go with it, [to believe] that I wouldn't somehow be betrayed...I felt somehow that something would go wrong.

The first stage in the healing process involves assessing, and often testing, the therapeutic relationship to determine whether it is "safe enough" to begin the work of healing. This occurs whether individuals have taken steps to maximize the chances of finding a safe context for working or whether the individual has trusted to luck.

Testing the therapist occurs on different levels. The therapist's response to memories of the abuse, however fragmented those memories may be, is one measure of the safety of the working relationship. Will the therapist, for example, follow-up on "hints" or oblique references to one's abuse, or will the therapist collude in maintaining silence? How will the therapist respond to disclosure of abuse? Will he or she listen, empathize, discount, minimize, rationalize, press for details, show horror, or be angry? How will the therapist respond when the individual begins to doubt the reality of his or her memories?

All of those situations provide opportunities for the individual to decide, either consciously or unconsciously, whether to trust the therapist. Merry, for example, described an incident where her first therapist, who presumably was simply trying to reassure her, failed to probe a feeling that Merry had:

> I went to a therapist, and I remember sitting in her office and feeling like I was this little tiny girl in this humungous chair, telling her about when I was three years old. My mother was taken to the hospital--she had a miscarriage--and I just wept, like I was still three, and I said to her, "I don't think anything happened during that time." And she said, "Well, you know, one of the most traumatic things for a child is to have a parent leave them," and that was that.

Almost a decade later, Merry re-entered therapy and began to retrieve memories of being sexually abused as a young girl during her mother's hospitalization.

How therapists respond to disclosures of abuse incidents is also important, as Elizabeth's description of turning points in therapy illustrates:

> Certain memories were kind of turning points...first I had my dad fondling me, and then remembering the oral sex, and then remembering the intercourse, and then

> remembering the ritual stuff, remembering the time--so at each stage--each point of that deeper level was always a turning point for me...it was like the first time...because every time, even after six years, I'm still leery sometimes. I am nowhere near as leery as I once was, but there's always that room for doubt because, you know, it takes a long, long time to really, really believe that someone's really going to be there...[someone who will say] it was valid or help to be able to look at it and [who] didn't fall over dead just because I said it. First of all, I was the one struck by lightning, and, when it got into the heavier stuff, it was really important for me, because it was so horrendous for me--it was really nice to have Jill just handle it. It wasn't like there was any widening of the eyes or feeling of "whoa." It was just like "yah"...[I] was just really ready to feel completely ashamed; I was so humiliated that I had ever been through this, so the quality of her response was very important. It's like, "OK, I've hidden this thing and I've brought it out for the first time and how you look upon it has a huge impact on how I'm going to look upon it, because my belief has always been that I can't look at this, or it's really awful, or it's really horrendous, but I'm thinking now, maybe for the first time, it may not be, so I'm going to show you and see what you think." So that response is critical.

All of the participants in the study had amnesia for at least some of the abuse incidents in their past at the point of entering therapy and, in some cases, individuals had no conscious memory of the abuse at all. When memories began to surface, one of the common reactions participants described was doubting the veracity of those memories. Often, in the initial stages, memories are extremely fragmented. Participants in the study, for example, reported experiencing flashes of visual images or recurring dreams or voices or sensations that had no clear meaning. Weiser (1990) also suggests that the propensity of individuals to experience dissociation during traumatic events gives the memories a dream-like quality, which may lead individuals to question the veracity of the memory. Finally, it is likely that the impetus to repress or deny the abuse continues to be operative. For all those reasons, individuals may express doubts about whether or not they were really abused as children. The response of one's therapist is again important in determining whether or not a working relationship is established, as Fiona's story illustrates.

Fiona's first memories of her abuse as a child came in the form of visual images of a very young girl being sexually abused. Initially, she interpreted the images as evidence that she must be having urges to molest a child herself. Eventually, she realized that she was the child and that the images were flashbacks of her own abuse. Her initial response to that realization was one of emotional release and relief that there was an explanation for the pictures that kept coming to mind, and then, "the doubts started setting in." Fiona's description of the contrast between the response of her therapist at the time and the response of her current therapist, both to her doubts and to the age regression she was experiencing with the surfacing of her memories, illustrates how that response can either halt or facilitate progress in therapy.

> He [previous therapist] would say it didn't matter if it happened or not. "The fact is that you think it happened, so you have to deal with those feelings," and it was just like "You are almost telling me I'm crazy; let's deal with the craziness stuff." That's not what I needed to hear...I was age regressing a lot at that point, and I would just sort of slip into this little kid, and he would just laugh and find it amusing....It's

> almost like I got stuck there, and I didn't go any further with that. I just sort of stayed there until I started seeing Ann, and then I started to come out of it....She didn't laugh; she didn't say it didn't matter if it was real or not. She said, "If you had this kind of a memory, then it's happened," and it was very validating.

Reactions of a therapist to information that reveals an unliked part of self is also important in determining whether the therapy relationship feels safe enough to take the risks necessary to make changes. Merry, for example, talked about her decision to make such a revelation to her therapist. It is obvious that a degree of trust had already been established in the relationship; it is also obvious from Merry's comments that the response allowed her to begin working at a different level:

> There were different stages during our therapeutic relationship...like finding out that she wasn't going to kick me out because I did something I viewed as horrific....I was terrified. I said to her, "Fern, do clients usually tell you everything?" And she looked at me and said, "Nobody's ever asked me that." And I said, "Well, I think I will feel better if I tell you this--I may feel better, but I don't know what will happen." And I told her, and...she said, after we had worked it through, "There, you see, we're still here, we're still together."

The fear of being abandoned and the need for reassurance that abandonment will not occur is one that a number of participants raised in speaking about the development of a safe working relationship. Stephen, for example, spoke about the fears that surfaced for him when his therapist suggested that he might find a group for male survivors of sexual abuse helpful:

> When I was going to get involved with that male support group,...I was very worried, and she said--she knew as soon as I walked into the office--she says, "So what's up?" So I talked about everything else, and she says, "So..." and I says, "Well, if I start going to see Peter and the support group, does that mean I can't come here any more?

Participants also talked about needing to know that it was safe to express whatever feelings they might have. In some instances, participants understood certain therapist responses as giving permission for the expression of a range of feelings, anger typically being the most problematic. Colleen, for example, described such a situation:

> I was talking about how I couldn't understand what was going on in my attacker's mind, and I was really trying to understand that, and, at one point, she just said quite forcefully, "There's no excuse for perverts," and I couldn't believe that somebody had actually said that about him. It gave me permission; it gave me the freedom to then say that...It was a way of giving me permission to have some of the anger.

More often, however, participants talked about situations where the response of the therapist to some expression of emotion led to the assessment that it was unsafe to express one's feelings in therapy. Diane, for example, described a situation where it was clear that her anger was not considered acceptable:

> I have come across several therapists that have a problem with anger....They would react kind of negatively if I showed anger. This one psychiatrist that I was seeing after my relationship with this guy broke up-- I was talking to him this one day and said something about him being a wimp, which he was--I tend to be very blunt--he seemed to react a bit defensively and said he may not be able to stand up for himself, but he is not a

> wimp....That shut me down and told me that it wasn't OK, even if it was the truth.

For Fiona, her first therapist's insistence that her mother really did love her was a message that her anger toward her mother was not acceptable, a view, as she says, that she shared in part:

> There is a part of me in the first therapist I was seeing..."You have to accept her, and you need to realize..." [In his view] I had to get to the point that I could accept that my mother really does love me, and it was an important part of the therapy process....so I really worked on that. I took this very seriously. "My mother loves me, my mother loves me. I'm going to accept that, I'm going to accept that." There is something wrong with me because I can't believe this. My mother must love me because mothers do, you know.

The process of "testing" the safety of the therapy relationship also extends to expression of feelings directed at the therapist or confrontation of one's therapist in situations where some intervention or response has not met the individual's needs. Fiona, for example, talked about needing to know that her expression of anger at not being advised of an upcoming absence was acceptable and not cause for problems in the therapy relationship. Merry needed to know that it was acceptable to have strong feelings for her therapist:

> I said to her once, "Well, I said to Joan [Merry's partner] the other day that you were becoming much too important to me"--meaning Fern [therapist], and then she just talked about how that shifts and changes, but never once did she say, "Well, that can't be happening; that's not valid."

Similarily, Elizabeth talked about her therapist's ability to accept feedback about a response as important in making the therapy relationship safe:

> There was one time where I had a dream about her, and we talked about that...I brought that in, kind of like, "Is this OK?" and then...she did something that I really wasn't OK with, and so I came back and told her that....It was really scary for me to do that. Had we not had the trust and had she not been so 100 percent supportive, I don't think I would have taken the risk....Once I took the risk in terms of saying this wasn't OK, then that kind of opened things up as well because she was like "you're right" and she was so good at saying "it's not about..." She really modeled an ability to handle feedback...she'll make her own decision whether it's right or wrong, but it certainly validated my experience....I [had] felt really unheard in the session. I just didn't feel like she got what I was saying, and I felt like we kind of switched off onto her agenda, so I told her, and she said, "I think you're right; I think I did." [Taking the risk was important] and, more importantly, her response, because the relationship's really important. Had Jill not responded that way,...I would have to question the whole therapeutic relationship. For it to be, for me, a healthy relationship, I need to be able to...give feedback. It needs to be two-way, and if she couldn't have accepted that, then we would probably not have gone much further.

The ability of therapists to accept feedback is important for a number of reasons. It is a demonstration that what the client feels about the session or about the relationship is important and, as such, it is demonstration of caring. It is also a demonstration of the therapist's own psychological health, a factor that was mentioned as important by a number of the participants in the study.

For Elizabeth, her therapist's ability to accept feedback was a sign of her therapist's own security. She could look after herself; Elizabeth did not have to look after her. "I think," she said, "for a therapist to be effective with a survivor, they just need to be incredibly integrated, incredibly conscious of their own inner world, have really healthy support systems, because otherwise it could get real messy, I think." Heather voiced a similar view in talking about the need for therapists to be able to look after their own reactions when she talked about her struggle to find alternatives to slashing herself.

The ability of therapists to look after their own reactions in dealing with intense pain and situations that may be truly horrific is important in the establishment and maintenance of clear boundaries. For Heather, the sense of clear boundaries in the therapy relationship helped create a safe environment for her to open the door to the feelings associated with her abuse:

> I got to a point of wanting to deal with this and feeling at some point, unconsciously making the decision that I was strong enough to open it up....[and] there's no confusion in my relationship with Jill [therapist] about roles....The relationship is quite clearly defined. I don't pay Jill...for me to listen to her problems. It's very clear that this is a place that I am constructing for that particular work....Jill is very clear. She is in charge in the sense that she is the therapist and this is the place for me to do my work, and I think those boundaries help a lot....

In many ways, then, the first stage of therapy involves assessing the therapy relationship and making a decision about whether the relationship, the interpersonal context in which work is to be done, is sufficiently safe to do that work. It is important, however, to recognize that the development of trust is a process that is ongoing in therapy. It is an incremental process of deepening that allows the individual to take the next step, the next risk. It is important, as Diane said in the interview, "to connect with the person that you are going to work with." For Merry, "the therapeutic relationship was essential...it was the pivot...it was the essential ingredient."

For many individuals, the relationship with a therapist *is* therapeutic. It not only provides a context in which healing can occur; it is an active ingredient in that process. There is, as Merry suggests, "something about the dynamic that strengthens the process." She found it difficult to imagine doing work needed for healing to occur without the help of a therapist; others such as George were less sure that a relationship with a primary therapist was necessary for healing to occur. There was no dispute, however, that healing occurs in the context of relationships with others and that relationships based on caring, acceptance, and respect are essential for healing to occur. Table 5 summarizes therapist attributes and behaviours which participants described as important in creating a safe environment.

Table 5

Therapist Attributes and Behaviours That Help Create a Safe Environment

1. Ability to show acceptance of the client and the client's feelings; part of that may involve "giving permission" to feel that which the client is afraid to express
2. Ability to understand and show understanding rather than communicating judgment
3. Ability to demonstrate caring, e.g. being responsive to client's needs
4. Ability to communicate support and encouragement
5. Ability to help the client feel "in control," not playing "expert" with respect to client's needs, respecting client choices, taking the lead from the client about what is important at any given time

6. Ability to "be present," to hear another's pain and to communicate empathy; not avoiding or denying; following up "hints," probing appropriately
7. Ability to set appropriate boundaries
8. Therapist expertise, i.e., particularly, knowledge about issues related to sexual abuse
9. The psychological health of the therapist; the ability of the therapist to look after self while doing the work of therapy

Making Other Connections

Many of the participants in the study expressed a need, at some point in their healing, to not be "alone" with the abuse, to know that others have had similar experiences. In some cases, individuals worked with therapists who were themselves survivors, and connection with "other survivors" could be made in that way. Fiona, for example, talked about the need to know she was not alone and the role her therapist was able to play, as a survivor herself, in meeting that need:

> What I needed early on was a lot of validation. [I needed] a lot of hearing about other people's stuff. Because Ann [therapist] is a survivor herself, she--there are some times where she shared stuff with me about her own experience without getting into a lot of stuff, but just to say "you're not alone." Very important.

In many cases, however, making connection with other survivors occurs outside the context of individual therapy. In some instances, that occurs through reading stories written by other survivors. In other instances, those connections were made in the context of time-limited groups for survivors of childhood sexual abuse. The stories of others, written or spoken, serve the purpose of letting survivors know, in a concrete way, that their experiences are not unique and that others have survived and found ways to heal.

In Elizabeth's opinion, participation in a survivors' group at some point in the healing process is "imperative":

> My therapist wasn't a survivor, so she had no idea--I needed to be around other women who had actually lived it, because there is a place where you just can't communicate. You need to live through it to really know. I don't think she needed to [be a survivor] to necessarily work with me so I could heal, but I needed that from somewhere.

Other participants in the study talked about the role of books written by survivors in helping them to feel less alone with respect to the abuse and reducing the sense of isolation that is often associated with a history of abuse. Accounts of other survivors may also give a name to experiences that individuals have had and help provide a framework for understanding those experiences. Fiona, for example, talked about one such experience:

> I read a book called Healing the Child Within and that was like my Bible for a long time....Somebody handed me the book, and I literally fell to the floor when I opened it and there was a part about dissociation. It was like, "God, that's what's happening." It was incredible because I didn't know; I didn't know what was going on. That was the first time I had seen it on paper or that anybody had brought it up and that book started me--probably the most--on trying to look after myself.

Marianne's experience in reading The Courage to Heal was a similar one:

> When I started reading that book, it was just like it was talking about my life....It struck so many tender cords inside of me, and yet, at the same time, I had tremendous relief.

There is something about seeing others struggle with the same kinds of feelings and the same kinds of issues that makes it easier to believe that there is an explanation for what one is experiencing other than one's own inadequacies and failures as a human being. There is also tremendous value from hearing others' stories in terms of generating hope that healing and change are possible, as Stephen's comments indicate:

> That book Trish Ashby-Rolls put out called Triumph was a wonderful book for me to read....It gave it all a direction, and it showed me that you can win, that you can triumph, if you will.

Groups for survivors can serve a number of other purposes as well. As was the case in Marianne's experience, groups can help one in shifting responsibility for the abuse away from self. Sometimes it is easier to see that the victim is not to blame when the victim is someone else. The more that belief becomes generalized, the easier it becomes to accept that as a truth in one's own situation as well.

Group experiences also have the potential to bring issues more quickly or more clearly into focus for individuals. Colleen, for example, talked about her first visit to the office where the group in which she was a participant met:

> I remember sitting in that chair and seeing all of these posters on the wall and they were saying things that,...deep inside, I felt shouldn't be said....So I had all of these--and I had to back to Fern and deal with the strength of these feelings--that I really had been silenced, and that this was really pushing buttons.

Elizabeth, similarily, talked about how her participation in group for survivors brought up issues related to the minimization of her own experience:

> My first group, I kept feeling like, "Oh, everybody's got such horrendous stories," little knowing--now my story's become a horrendous story--and feeling like, "Oh, mine's not important," and that brings up--it's a faster way to light up or bring to the surface issues that need to be addressed.

Although making connections with other survivors in the context of time-limited groups was important for many of the participants, making long-term, ongoing connections with others was also important. Such connections provide a sense of belonging to some larger group that has, as its purpose, sharing and mutual support. Making such connections may involve re-establishing family ties, where possible, or finding some community, in the general sense of the word, to which one can belong.

Survivors are often in the situation where there is little family support as some of the previous excerpts cited have illustrated. There are cases, however, where individuals are able to re-establish some family ties. Elizabeth was able to establish some connection with her mother after her father's death. Colleen was able to work through issues related to her difficulty in telling her mother about her abuse by a neighbour as a child and to solicit her support when she decided to have her second child at home. Stephen was able to establish some sense of connection with his mother, which was very important for him, and, through her, with other members of his family. In doing so, his family members, all of whom had some history of sexual assault, as children or as adults, have been able to offer each other some support in dealing with issues related to that abuse.

In general, however, the focus of participants in the study was on developing supports outside the family. Sometimes friends played important roles in that regard. Marianne and Helene, for example, explicitly mentioned existing networks of friends as being important sources of support in their healing. Others talked about developing supportive friendships through their involvement in various groups or organizations. George, for example, talked about how important the development of friendships with other men involved in 12-step groups to which he belongs is:

> I have some really neat people in my life right now today. I have probably half a dozen men than I can call over anything...for me, that was a neat gift. I never had a soul that I told anything to.

In addition to providing opportunities for making friends and providing a source of ongoing support, involvement in such groups also provides opportunities to see people make significant changes over time and reinforces the belief that change is possible. For George, the sense of belonging to a community focused on supporting the growth of its members was very important:

> I was at a men's 12-step thing a month ago--a couple of guys were 42 years in the program [and had made] significant changes...You're talking of a life-long--like it's a journey. There's a bunch of people you can just grow with. I don't see that happening with any kind of organized therapy. I've been in groups; they only last for eight months. Even if you went to a group that lasted two years,two years is nothing; it's just a spit in the bucket of life. The sense of community [is very important]...the idea that they love [me] enough to help me love myself...and I know I don't have to do this alone.

A number of participants in the study were involved, or had been involved in the past, in twelve-step groups, and it is clear that they do provide, for some individuals, a sense of community and a source of support for recovery. For others, ongoing self-help support groups provide a similar function. For Helene, her involvement with the native community and her participation in native sweat lodge ceremonies provided an opportunity for ongoing healing and growth. Finally, a number of participants talked about the importance of a developing spirituality in their lives that reinforced their sense of connection both to others and to some power greater than self.

The importance of having a sense of connection with others and feeling that one is no longer alone with the abuse is clearly important for healing. Pain shared, and support given, changes the context in which the abuse exists. For the participants in this study, those opportunities did not exist in childhood. When the context in which the abuse is experienced changes, the meaning of the abuse can also change.

Building Internal Resources: Strengthening Self

One of the early tasks in therapy is developing the internal resources needed to deal with memories of childhood abuse and to make changes in one's life in the present. As Elizabeth noted during the interview, "the very nature of the abuse leaves me in a place that the skills I need to heal myself, I don't have," and it is important that therapists recognize the degree to which that is true for all clients with a history of childhood sexual abuse. Developing those skills and strengthening the individual is, then, the first order of business for many individuals. One of the recurring themes in the interviews conducted for this study related to the beliefs expressed by participants that the intensity of memories and associated issues surfacing was directly related to the degree of "inner strength" experienced. In Diane's words, to deal with being abused as a child "takes a lot of inner strength, and it's not a strength everyone has." For most individuals, it is not a strength that most are aware of having at the outset of therapy.

Strengthening the self has a number of different facets and includes learning to recognize existing resources and skills as well as learning new skills and developing new resources. The following is a description of the attitudes and behaviours that participants identified as important in the process of becoming "stronger."

Increasing Self-Awareness

Two particular skills related to increasing self-awareness that participants identified as important in the healing process were the ability to identify one's feelings and the ability to identify one's needs.

Learning to Identify Feelings. For many individuals, surviving childhood abuse means learning to shut out feelings such as fear and rage that have the potential to overwhelm the individual, if experienced, or to result in punishment, if expressed. For many individuals, psychic survival also means learning to deny the needs that one has that are seldom or never met. As a result, adult survivors often feel "out of touch" with their feelings, have difficulty identifying the feelings they do experience, and have difficulty identifying their needs.

For Diane, starting to recognize the feelings she had was the first step in the healing process. There were a number of elements in that process. One was a therapist who was able to challenge the picture she was presenting of her father in a way that allowed Diane to begin to examine her feelings:

> When I started talking to her about him, I was talking about how good he was and what a great father I had. She had the nerve to suggest that I might be angry with him. It was pretty hard for me to accept that I had any anger towards him....I rejected it at first, and then she started pointing out, "How do you feel about the fact that he was never home and the fact that he was always making you move?" Once I started thinking about it, I started realizing maybe I was angry...I'm sure she could see the anger in me...[Being able to acknowledge the anger] laid the groundwork. That was the start of the foundation I have been working on ever since.

In addition to individual therapy, the hospital program in which Diane was involved included intensive group work focused on identifying and expressing feelings. She talked about the importance of feeling part of the group, but the skills she began to develop were also important for her:

> Something else I got from the group...is permission to feel...I think that was something that I desperately needed; I don't just think, I know I did. I had no idea that I had as many emotions as I did. I just felt rotten, and some days I felt worse, and that was about the full expanse, the full depth, of my range. A couple of months later, I started getting memories.

The process of learning to attend to and identify feelings may be a difficult one where it involves changing longstanding patterns of coping. It is, however, a skill that is a necessary prerequisite to being able to identify needs and desires. It is a skill necessary for growth and a skill necessary for self-protection, as Diane's comments indicate:

> For me, [learning to assess the trustworthiness of people] was just paying attention to how I felt around people, watching how they treated me and how I felt about it....The first counsellor I had at the Sexual Assault Centre was the one that really got me thinking about that. She really stressed trusting my gut reaction to things. It was a long time before I could even figure out what my guts were trying to tell me, and then, to not only recognize them, but to start paying attention to them and acknowledging them and saying, "Yeah, this is valid; this is a feeling I have and it's there for a reason." I started out just for the hour that I would go to see my counsellor. I would work hard at trying to sort out what was inside. It took so much effort that was about all I could handle.

Part of learning to identify feelings also involves learning to distinguish emotions that are "primary" from emotions that serve a defensive function (Greenberg & Safran, 1987). For Fiona, learning to recognize the hurt and feelings of fear and powerlessness that underlay her anger was an important step:

> I am a lot better with feeling the hurt. For a long time, it took months before I'd get angry and months before I could feel the hurt underneath. Now I will get angry, but mostly I will feel the hurt real fast. And, when I do get angry, I have an idea of what's OK, understandable anger and what's "I need power, I am frightened, and I am trying not to feel anything else, so I will grab my anger." And I recognize that really fast.

Because it was so pervasive and so generalized, her anger was a source of self-loathing. The ability to recognize the hurt underlying her anger was, therefore, very important for Fiona. As she began to be able to direct the anger to its source, she became much more able to contain it:

> [If I can feel the hurt] then I know I am getting better....[by] the same token, to feel the anger towards my mom...I know I am getting better, too, because I couldn't associate the anger with her. It's like I just placed it everywhere.

Being able to identify the source of one's emotional responses is also part of becoming more aware of one's emotional state. Marianne, for example, talked about the development of that ability as important for her:

> Sometimes, when I don't feel good now, I can stop and I can sit down and...I just sort of backtrack what's happened in the last three hours or what's happened in the last day....When did I start feeling kind of down or negative, and a lot of times I can pin it onto some silly little thing that I didn't really recognize at the time as affecting me, but it just put me in a bad state of mind. And, once I do that, I can feel good again....Before, I would never be able to do that. I would just feel really down and then you just--you don't think that there's a reason why you feel this way. So I am just more sensitive now to my feelings.

Learning to look for the source of her feelings was a process that Marianne described as being modeled by her therapist. Having someone ask her about what had been happening or asking her to reflect on what had been happening, and having someone assume that there *was* a reason, was the beginning of that process for Marianne.

Marianne also talked about the importance of modeling in another context. One difficulty she identified was finding the words to describe her feelings. For her, being able to read others' accounts of their feelings and being able to listen, in group, to others' accounts gave her the words she needed to express some of her own feelings:

> When I first started dealing with this issue, if somebody would have asked me how I feel, my mind would have come up blank. I could not relate to my body. I could not relate to my feelings and actually verbalize that today I am feeling sad. I have noticed that when I go--we have a chiropractor that we go to and he does...reflexology...he works on different pressure points. And I noticed one day that he working on my feet and I'm mentally--I'm trying to disconnect from his feeling my feet. Things like that, I never would have picked up on before, but it's just that I am becoming so much more aware now of my body and my feelings and listening to my body....Two years ago I wouldn't have been able to put into words how I feel or what I am thinking...and that's one thing I really appreciate. [I learned to do that] from reading self-help books, from hearing people put into words, feelings...other people saying how they feel...and then I realize I feel that, too.

Helene, also, talked about the process of learning to identify her feelings, after years of deadening them to survive, and her envy of friends whose emotional response to events seems immediate:

> For me, part of it was that I had to learn to recognize what emotions were what. Then I had to learn what to do with them and how to articulate them or use them or whatever. And I am still very slow at recognizing what I am angry about, but you know...[my partner] and I were just joking about this the other day, and I said, "It used to take me two weeks, and now it takes me two days, and I can say I am really pissed off about something, and I am not sure what".... [The other part of it is that] the abuse experience is so intense...that you have to retrain yourself out of that as the experience, as the only experience or the only emotional response, because it integrates every emotional possibility.

The process of learning to identify one's emotions is, as suggested in the above accounts, a complex one. It means learning to attend to the self in a way that is in stark contrast to the years of learning to ignore internal signals. It means learning to distinguish feelings whose function is defensive from feelings that may be threatening or difficult to handle. It means training the self to look for connections between events and feelings. Above all, it means risking the experience of emotions that one has avoided for many years.

The process of learning to identify feelings is closely related to learning to express those feelings. As Marianne indicated above, part of being able to identify feelings was having the words to express those feelings. Sometimes, it is in the expression of the feeling that it becomes identifiable by the individual. Sometimes the expression allows another to name the emotion, to help teach, in the same way that healthy parents teach very young children to label and make distinctions between various emotional states.

For many of the participants in this study, drawing and writing were important vehicles in the identification of feelings. Fiona, for example, identified learning how to draw pictures to "tap into" into feelings as a very powerful tool in helping her to become more aware of herself. Elizabeth similarily talked about using drawing to access and express emotions:

> The drawing is probably the most powerful for me because when I draw it--suddenly from wherever--my body--I can be having a feeling and I'll just draw a picture and suddenly the feeling is out and sometimes I need to do more with it and sometimes I don't. [It's a way of] releasing.

For others, writing serves a similar purpose. Merry, for example, talked about how important her writing was in providing an outlet for the feelings that were bubbling to the surface when she first began therapy. For Heather, writing has been an important tool in allowing her to become more aware of her own internal state as well as serving a number of other functions.

It is clear from the above that there are a number of ways that therapists can facilitate the growth of self-awareness. One is simply encouragement of clients to attend to their physical and emotional state. Another is asking questions that direct an individual's attention to feelings or to the connection between events and feelings. A third is encouragement to explore a variety of media for expression of feelings. A fourth is the kind of reflection that helps give words to feelings, to label and distinguish them. A fifth is probing for the emotions that may be masked by anger or sadness. In all those ways, therapists can create a framework that supports increasing self-awareness about emotions.

Learning to Identify Needs. One other aspect of increasing self-awareness is learning to identify one's needs. The identification of needs is closely related to the identification of emotional states in many instances. As Greenberg & Safran (1987) note, "primary feelings serve to inform people about potentially helpful action patterns in response to the environment" (p. 187). When individuals are able to identify fear or anger or sadness or joy and the sources of those emotions, they are able to consider actions to cause the cessation or maintenance of those emotions.

The process of becoming more aware of one's needs is very similar to the process of becoming more aware of one's feelings. In large part, it means attending to oneself, acknowledging that one has needs, and finding the words to express those needs. The way in which therapists facilitate that process is also similar. Direction to attend to one's needs sets a framework that presupposes needs exist and helps legitimize them as well as helping to focus attention on needs rather than away from them.

When a therapist gives direction to a client about a particular course of action, the therapist is undermining the development of the client's skill in identifying needs. Sometimes, particularly in crisis situations, it is easy for mental health professionals to assume that they know what is needed because of the obvious difficulty that the individual has in identifying and verbalizing her or his needs. In the long run, however, such actions are likely to be more of an impediment to growth than an aid, as Diane's story illustrates:

> I was quite suicidal about nine years ago. The psychiatrist that was treating me right then kept trying to push me into a group home situation. What I really needed right then was to start learning to live with myself. I had been in a really destructive relationship, and it was kind of the straw that broke the camel's back. I had a breakdown at the end of the relationship. Emotionally, I was just all over the place. There, again, I played my part in it. It was impossible for me to put voice to exactly what it was I did need because I didn't know. The one thing I did know is that once the relationship broke up, I knew that I couldn't live with anybody ever again--even have a roommate or anything--

> until I could learn to live with myself, however long that took. I didn't know how to put that in words. He pushed that at me several times--that usually after a suicide attempt....I can understand his position, but that was the last thing I needed.

Table 6 below summarizes ways identified by participants in which therapists can facilitate the growth of self-awareness.

Table 6

Ways in Which Therapists can Facilitate the Growth of Self-Awareness

1. Encouraging clients to attend to physical and emotional states
2. Asking questions that direct attention to feelings or the connections between events and feelings
3. Encouraging clients to explore various media for expressing feelings, e.g., writing, art, dance
4. Helping clients to label feelings
5. Probing for emotions that may be masked by anger or sadness
6. Asking questions that direct attention to needs or to the connection between feelings and needs

Learning to Nurture and Care For Self

Learning to nurture and care for self is both one of the central elements of recovery as well as a necessary element in developing the strength to handle the memories of one's abuse. Learning to do so requires some awareness of one's needs, but it also requires some skills. Part of learning to care for oneself involves learning how to comfort or soothe oneself when in pain. Part of it involves learning how to take time for oneself and set limits in relationships with others. Part of it involves learning how to "pace oneself" to modulate the level of affect associated with remembering and exploring one's abuse. Part of it involves learning to reach out to others for support and asking for what one needs as well as learning to be assertive in other ways. In addition to learning those skills, learning to care for oneself means learning to appreciate that one deserves good treatment.

The consequences of being abused and neglected in childhood are that individuals often grow up, not only having difficulty identifying their needs, but also not having any sense of deserving to have one's needs met. As Marianne says, in the following excerpt where she describes the changes she has made with respect to caring for herself, it is difficult to believe that one is entitled to good treatment if one has never received it:

> I take care of myself now. When I am tired, I just take my rest, and I don't really care what other people are doing or if they expect me to be doing something. I just say, "I'm sorry. I have to sleep today. Today I'm sleeping." And that's it....One thing that really helped me [to do that] was when I went for group therapy--people talking about taking care of themselves. I never, ever thought of taking care of myself before. I always felt that anybody that takes care of themself is being selfish, but now I realize that it's not being selfish....You have to take care of yourself and, if you don't take care of yourself, you're really no good to anybody. Before I never felt entitled to do that. I always remember every--like from one week to the next--when I'd go to group therapy, our instructor...would always say to take care of yourself, and I always felt so good when she said to take care of yourself, because I never felt--I guess I never felt that anybody ever took care of me and, as a result, you don't think you are worth taking care of. I really appreciated that and I felt good, too, because I wasn't being selfish. In the

> Bible it says "love your neighbour as yourself" and, if you don't love yourself, how can you love anybody? So I realized it was just my own interpretation because of how I was raised--that you don't expect you're worth anything, so you don't treat yourself like you are worth anything. I don't know really [what allowed me to hear that message] but I remember [it being repeated]. From one week to the next, you forget. It took until almost the last few sessions [before] I finally started to realize that I have to take of myself.

Diane, similarily, talked about beginning to feel that she deserved to have her needs met and the difficulties that she had to overcome in order for that change to occur. While she talks about learning how to nurture herself, implicit in her comments is also the importance of feeling cared about by others in the process of recognizing one's needs for love:

> I'm starting to feel that I deserve to have some of my needs met. Because they were unmet at such an early age, I started feeling ashamed for having needs. I just assumed that it was a pain that was inside me, but it wasn't something that anybody would ever do anything about [or] could do anything about or that I even had a right to say anything--that I had these needs....By the time I was a teenager, I didn't know what a need was. I didn't know that human beings need things like being hugged and held and kissed and nurtured or to feel loved. I just didn't know that because I had never seen it. I am starting to be able to give some of that to myself. There are some things, some needs, that I have that will never get met through somebody else....I have to find a way to do it to myself...they're child needs, unmet needs that need to be met, like cuddling, hugging. I wrap myself in a sheet sometimes and lay down on the couch and watch TV, or sometimes, I go to sleep that way.

Some of the participants in the study identified learning to care for self as one of the most important changes in therapy. For Colleen, learning to care for herself and comfort herself was related to her ability to trust herself. Helene also identified learning to care for herself as one of the most important changes in therapy because she also saw it as related to expectations about treatment by others. Often the way in which such changes begin are very small, as Helene's account of "learning to take a bath" illustrates:

> That's a gift Jill really has, making you find ways of taking care of yourself. She insisted, for example, that I take baths instead of showers because I was so efficient in the shower. "Why do you take a shower?" "Because it's so efficient." "Right, take a bath," she said. So she really sort of reinforced, and enforced, in therapy, taking care of yourself in ways that you can....After my marriage broke up, I went through a terrible affair....When I was eating alone and feeling glum about it, I would light candles and turn down the lights and put on some nice music....So all those kinds of mechanisms where you just try and find ways of being nicer to yourself. I think if you have been abused as a child--I don't know anybody who hasn't been abused in some way that doesn't feel like they were deserving of it. In my case, it kind of helped because he was such an asshole and would say, "You belong in the gutter, you're scum, you're this, you're that." [But] you can't help, when there is a person in power, believing that. Even if you know that it's not true, there's a difference between knowing and believing. So learning to take a bath instead of a shower is saying that [I deserve to be treated well]. And I don't think you get--I guess, for me, I don't think I would have got anywhere without learning that. I certainly wouldn't be functioning the way I am now, because that's everywhere. If you go into

> a situation and feel like you are not going to be treated well, then it's pretty clear you won't.

It is obviously easier to care for oneself when one feels deserving of care, and part of therapy may involve challenging the beliefs associated with not feeling worthy of care. However, it is interesting to note that for many of the participants feelings of some entitlement to such care often followed acting "as if" one were entitled. That is, the more that participants took steps to be "nicer" to themselves, the more that sense of feeling worthy grew.

The ways in which participants learned to care for themselves were quite varied. In some cases, individuals spoke about finding ways to nurture themselves emotionally or to soothe or comfort self, as Fiona's comments illustrate:

> I would suck my thumb--hard to do in public--but that was one way I nurtured myself. I allowed myself to do that and it was almost instamatic. Any time I needed comforting my thumb would be in my mouth like that....I got a soother for at night and a teddy bear and sometimes I'll leave the light on....Those are...ways that I emotionally took care of myself that I didn't get a lot of. Sometimes I would visualize holding myself; sometimes I would try holding myself; and other times, I would just visualize somebody rubbing my back, touching me in nice ways.

For Elizabeth, learning to emotionally nurture herself meant learning how to use her "adult" self to meet the needs of her "child" self, a process that she described as learning to parent herself, with the help of her therapist:

> What we did, which was really useful for me, was we'd go back to each memory and have me as an adult go back and rescue my little girl or talk to my dad and kind of re-enact that. The first few times was like, "No, no, no. I don't want to do this."...The hardest thing in the world was for me to close my eyes and go back and go in

> as an adult to rescue this little girl. It's like, "I don't know how." And I used to complain all the time, because, if I can, I don't want to. I didn't want to have anything to do with my inner child....it was like she was too needy. I didn't have the skills. I was so terrified. I didn't know what to do. So it's almost like the parental part of me got taught how to parent, and Jill fulfilled that. When you are teaching someone how to parent,...you do it through modeling, and eventually you learn how, and you start to apply the skills....The danger there is that the therapist remains the parent. At some point, there has to be a crossover. Jill was really careful.

Images of self or others who protect and provide care can be very powerful sources of comfort. In the above example, it was clear that Elizabeth was learning to care for herself. In other cases, individuals were able to use images of others to care for the part of self that was damaged by the abuse. Those images may be generated in many ways. In Helene's case, the images were generated in the context of native healing rituals. During the interview, she talked about her experience of "being given a grandfather" in the sweat lodge to look after the part of her that was still an abused child. She had been having fragments of memories, visual images flashing into consciousness that made no sense to her, and she entered the sweat lodge asking for guidance in understanding what was happening to her. What follows is an account of her experience:

> There are different rounds in the sweat lodge, and in the first round, I was getting all of the images. They were just totally chaotic and unstructured, and it was all about my face, which helped a lot because I have a five year old and a two year old, and I really have trouble when they put something close to my face....I thought it was because of being struck so much as a kid on my face,

> but realized it wasn't that at all. It was from having these genitals in my face and these pants in my face and all of that....That was the first round....after the first round, the sweat leader was telling the story of bringing the pipe to the people so I was sort of listening to that and saying, "Well, I am really glad I found out what was happening here and that now I can rest in the next three rounds"....in the next round, I had--they call it a vision--of a grandfather, and I, as a four and a half or five year old, just ran to him, and he picked me up and the [grandfather]--they call it grandmothers and grandfathers--told me that whenever she was in trouble, he would take care of her, so that was an incredible gift for me....I just had to take care of my stuff. Because you can't--I can't take care of her myself...somebody else has to because you are not her anymore...you would be frightened for her without knowing she is now protected...[so it frees you to go on], to do what you [need to do].

After the death of Helene's stepfather, a man who was extremely violent, to the point of threatening her life with a gun as a child on more than one occasion, she had a vision of her "grandfather" engaged in battle with her stepfather's spirit and defeating him. For Helene:

> That's an incredible, powerful image to be able to carry around; they are very strong images...I haven't had--I have felt very alone in dealing with stuff...so that, as a symbolic image or whatever it is, the gift of a grandfather has been really important to me....Maybe part of it, too, was the decision to [go away to university], uprooting my family and the whole thing...and maybe it became important to put my energy into that, and maybe, then, the grandfather is a way of saying, "You are going to be able to do this because I am going to take care of him and I am going to take care of her....they are the

> steps of loosening--I don't want to say the ties that bind, but it is a kind of loosening of the clout of the experience--and I don't mean the power of the experience, but just the clout.

Learning to care for oneself also means learning how to take time for oneself and how to set some limits in relationships with others. Merry's account, which follows, is interesting in that regard because it also shows how a therapist can help structure such time in a way that begins to change old patterns:

> Despite the fact that I had other people around me, I found yet another surprise. I needed the time alone; there were some things I felt I could only do alone, and I guess that is where the bathtub stuff came in and the just sitting in my back yard. I think there was a real sense of the realization that I could be alone and that I could help myself. I am cognizant enough and caring enough and just able to look after myself....It's very, very important that no matter what I have been doing...that I have a chance to come back to myself after....[In the beginning], Fern actually made me [take time for myself]. Together we would do it, and then I would have a tape to take home...It gave me a vehicle to start with that I had my initial meditation tape...and then I had a couple of others....So those gave me the starting point, that this time became very, very important to me, essential to my well-being....and I think it just built on that. I started to--the kids would get so that they would say, "Are you taking the phone, or are you meditating?" I was always at everyone's beck and call. I have an answering machine, and I use that to my advantage [now]. I'm not as willing just to be there, always available.

Sometimes learning to take care of oneself occurs in a very practical realm, as Fiona's comments about becoming financially independent illustrate:

> I still don't have a lot of money, I have no time to do anything, but I can pay the bills and that feels good. It feels good in that I don't know that I can honestly say there has been too many times in my life that I have been taking care of myself in the outside sense, but that's an important sense, too, and so it feels good to do that.

Sometimes learning how to take care of oneself means learning how to pace oneself, to prevent oneself from becoming emotionally overwhelmed by one's experience. For individuals who enter therapy in a state of crisis, it is important that the situation be stabilized and that the individual develop the skills and resources needed to lessen the risk of being overwhelmed. Stephen talked about a number of strategies used by his therapist to help him develop those skills and help him regain his balance:

> [In therapy, at the beginning] I wanted to stop my head from blowing up. There was too much thought in it...it felt like a balloon that was getting bigger and bigger. I couldn't organize them [the thoughts]...at work, at home, everywhere...I had just become so disorganized....Maureen started helping me put my thoughts back together....[By] directions [and] just talk. She would start by, "Well, try and leave this here today."....When I went in, my thoughts were so disorganized--I'd go from when I was 3 to 15 and back to 7 and back to...there was no direction to it. Now, I've targeted some areas that I know need work.

Later he talked about how helpful it was to him to be able to deal with his experience a little a time:

> In one meeting I've never fully discussed anything with Maureen. I'd spit a little bit of it out and then the

> next time I go, we'll come back to it a little bit. It's been a very gentle process to open up the boxes. One time--I always used to tell her how scared I'd get when I looked into them--and I referred to it only because she brought it up--on how there wasn't too much left in the box and [I] could actually see the bottom, when in the beginning I was just terrified to touch it.

For Stephen, learning how to take a break was also important:

> One of the things that Maureen has helped me to learn how to do is to say no to myself, or "my kids", if you will. When I was going on holidays, she says, "Now you know you are going [on holiday] to have fun. I want you to go and play and, if you want to play with your kids, go with them all you want, but you are going to have fun. Don't let them be hard on you." And I was walking down the beach one morning...[when] the old "what are you doing here?" thoughts kicked in--"what right do you have to be having fun?" And I, just out loud, said, "No, get out of here. Go, where you're supposed to be, at Maureen's. Go, leave me alone." And I had to chuckle because...that's all it took.

For Colleen, learning to pace herself, to take breaks, and to deal with "one thing at a time" was also very important. The following is an account of a dream that she had early in therapy where she described learning that she didn't need to follow the culturally dominant mores associated with "success" and that she could accomplish her goals "one pin at a time":

> I have to tell you my bowling dream....I came in one day quite early on in the process when I was--it was just around the time when I was just really learning to trust Fern and learning to accept some of the looseness. She was getting me to loosen up in a lot of ways--to accept joking around, goofing off in therapy, that goofing off was OK. And I had this really wonderful dream where I

dreamt that Fern and I went bowling. We were in Biggar, Saskatchewan, in the Legion, which is sort of down in the basement of this building on Main Street. We had gone down there and they had converted the entire hall, the Legion Hall, into a bowling alley. There was all these old guys sitting around a card table, and they were having a bowling tournament. We had seen the signs, and we decided that we wanted to join this bowling tournament and compete with these guys. We went down, and the first part of the dream was Fern and I debating with these guys about whether or not we should be allowed to bowl. We were women and weren't supposed to be--and we weren't Legionnaires. So, after a while, they conceded and they allowed us to join their bowling tournament. At first I got up and started to bowl and everybody was watching, and I started to bowl and I got a strike...I was really happy, and I looked around at Fern and she was just shaking her head, and I couldn't quite figure this out. I thought I was doing fine. So I got another ball, and I rolled it down there, and I got another strike, and I looked and she's just going, "t-t-t-t...no, no, no," and I couldn't figure this out. So I went and sat down for awhile, and then she got up and picked up this bowling ball...and sent this ball down, and it took out one pin on the right hand side. She took out one pin, and she looked very happy, very pleased with herself, and she went back and she took out the next pin, and she did this all the way down the line. And I was looking at her and going, "Fern, what are you doing?" and all these guys are going, "What is she doing?" And she looked at me and she said, "These are women's rules; one pin at a time."

I had just realized that a very important thing for me was going to be doing one thing at a time and that I couldn't make all these changes all at once. I was very impatient to have everything sort itself out, and she had

> been trying to get me to slow down a little bit. That was part of it, too, learning to pace myself and take breaks and feel good in between doing all of these things. She did that very well for me. She reminded me. And just dealing with one thing at a time. If I came into the session and had 20 things on my plate, it was, "What will we deal with today and what can we do about the rest to kind of put it away?" And, using hypnosis, too--a number of times we did things to keep me from feeling overwhelmed--never to ignore things, but just to put them to one side for a little while to focus intently on other things.

Developing Confidence

Learning to take care of oneself also means learning that one has the ability to do so, that one has the strength and the resources to meet one's own needs in a variety of ways. For some individuals, the ability to comfort self was important in allowing themselves to risk experiencing the emotions associated with their abuse. For most, the confidence that one could look after self grew incrementally by taking small steps to do so. Heather, for example, said that there were a number of steps that she needed to take before she could risk "opening up" emotionally:

> Part of my work with Jill is working on much smaller and less intense issues that needed my attention. I had to come into a relationship with knowing that--a relationship with myself in a way--that I would be able to take care of things no matter what. And that has been a very slow process of working on small issues that aren't devastating and handling them and making decisions and trusting my own assessments of situations. Just sort of strengthening that process of trust and knowing that I will be all right to take care of myself no matter what. That has been the longest process, and I really had to--like learning to walk in some ways--before I

> could tackle the big--the big memories. [It was not only building confidence but gaining] experience as well....Part of it for me has been just developing a relationship with the feelings that are there and understanding what they are about and how intense they are and why and getting experience, I think, just dealing with them after not having dealt with feelings for such a long time.

As Heather developed the confidence in her ability to look after herself, the range of acceptable options for action also began to expand:

> It's...a sense of just being a lot stronger which I guess generates a sense of more options than being, or feeling, not very strong and really needing this and this and this in order to....I have real trouble having people in my space and in my apartment and feeling safe with them there at the same time. I feel the most safe when I have nobody else around me, and my door is locked, and my rent is paid, and the bills are taken care of, and it's fundamentally mine. That is when I feel the most safe, but I have been learning to open it up and still feel safe at the same time and that I do have choices to ask someone to leave if I don't want them there. Whereas, before, certainly in relationships--abandonment issues are [enormous]. If something doesn't work out exactly right, then the option is always--or the only emotional response...seems to be..."I have been abandoned" or "I will be abandoned if I don't do X." I think, having worked out some of those feelings, I feel more capable of taking care of myself, no matter what, so the anxiety around abandonment isn't as intense.

Developing confidence in one's abilities is important in other spheres as well, as Fiona's comments above about the importance of being able to support herself financially attest. Diane, similarily, talked about the importance of being asked to edit a newsletter and realizing that she could handle that responsibility. Again, having the confidence that one can look after oneself and that one can handle responsibility is important in building self-esteem and in expanding one's options.

Developing confidence is also related to learning to appreciate one's own strengths. Typically, individuals enter therapy focused on problems and perceived weaknesses. Shifting that focus is important in building strength. That does not mean denying the problems that have brought an individual to therapy or the feelings that the individual has. However, it does mean beginning the process of understanding the situation and the self differently. Helene, for example, talked about the positive effects of learning to see oneself as a survivor, rather than a victim. For Colleen, her therapist's skill in helping her to shift her focus to her resources, particularly when she was feeling overwhelmed, allowed her to begin to develop that skill as well.

Identifying skills that have been developed in the course of living in an abusive situation and learning to use those skills positively is part of shifting the perspective from the negative to the positive. In the course of therapy, for example, Merry began to realize that her skill at "shutting things down" was one that had positive value in the present as well:

> I was so skilful [at shutting it down], but then I even got so that if I felt that I needed to shut it down for awhile, I would do that, because this wasn't a race.

Helene, similarily, was able to recognize the positive value in the present of the hyperalertness developed for purposes of self-protection as a child:

> That's something else you have as an abuse survivor. I can make the fastest fix on people, especially men, of anyone I know...so there are really positive things like that where I can just--I have this extra--I think people

> have like little extra hairs that wave around, extra antennae....I can pick up stuff a lot sooner than other people--what's going on in a lot of ways. As a child, you just learn to be so attentive and so careful and to watch everything, in part, I think because, as a child, you really think that if you can figure out the trick, it won't happen--if you can figure it out, then you won't be beaten up, you won't be abused....That sort of training as a kid that you get--you just develop extra antennae and you learn to use them as an adult for your own good.

The realization that one has the resources within to meet one's own needs is also an important element in developing confidence. That occurs in a number of different ways, for example, realizing that one can take steps to comfort oneself, to access memories of safety and peace, and so on. Some participants described learning to use dreams and images accessed in trance work as important in feeling that they had answers inside themselves. In the following excerpt, Colleen describes the importance of one such incident in helping her to believe that, in turning inward, she could find what she needed to heal:

> We worked a lot with two different parts of me, with the adult and the child....Spontaneously, in a dream, I did come into contact with this child inside me and found that I was in a kind of a battle with this child, that the adult was not able to convince the child that she could take care of her and that she could comfort her and all those things. And, using hypnosis, at one point, Fern had me come face to face with that child and then there was a wonderful moment when she had the child give me a gift. And, instantly, in this trance, there appeared in my head--there was a pine cone. When I came out of the trance, I remembered that when I was in biology class in Grade 11 I was fascinated by these little Douglas fir pine cones because the only way that

> they will germinate is through fire and so this became an incredible symbol for me....It amazed me that I had that inside of me and it just sort of came out....We used that a lot and I found, from that moment on, that there was a whole series of symbols that came up for me and we used those a lot. They were very helpful in that they came from me. They were messages from inside of me, and having somebody recognize that and share that with me was really important. It--all of a sudden, it meant that I could turn inside, that I did have some of the answers myself to these dilemmas I was facing constantly, but I didn't think I had any answers to.

That kind of experience is important in developing the sense that one has answers within. Several of the participants also talked about the importance of their therapists' stated belief that they had those resources. For Stephen, that was one of the messages he received early in therapy:

> When I first went in and started to see Maureen, she says, "You know all the things that in the long term that I am going to help you see you already have. It's just maybe you forgot where you put them." And it's been a very apropos description of the way it's been for me.

Messages of that kind not only suggest a sense of confidence in and respect for the individual, they also help to create a state of mind in which the individual begins to look inside for those resources. The more the individual begins to find resources and strengths with the self, the more confidence develops and, as Heather suggested, the more options become open and the more possible change becomes.

Learning to Trust Oneself

Developing confidence in oneself is integrally related to the issue of learning to trust oneself. Many of the participants spoke of learning to trust themselves in the sense of learning to rely on self. That is, they were able to trust themselves because they had the confidence that they would be able to look after themselves. In Stephen's words:

> I think a lot of the work that I have done has been just laying the groundwork, the foundation....[for me, the foundation is] to trust myself, to believe in myself, to know that if I started to fall, the only person that I had to reach out for was me....[it means] when I get troubled, I can pull myself out of the abyss, if you will. I can offer myself direction now.

Learning to trust oneself is an issue also, however, in the sense of learning to believe that one's perceptions are valid and that one's emotional reactions occur for a reason. Many of the participants in the study spoke of periods of feeling uncertain about what was real or not real or periods where they felt as if flashbacks or emotional reactions, particularly emotional reactions dissociated from their source, were an indication of losing sanity. Where children grow up with little or no consensual validation of their experience because the reality of the abuse and its impact is denied, it is difficult to develop a trust in one's perceptions and emotional reactions. As Elizabeth indicated in the interview, regaining that sense of trust in self is a process that may be lengthy:

> It took a long time to be able to validate myself, and there are still times when I lose it....When I say validate myself, I guess it's to say that either "yes, this happened" or "yes, what you are feeling is OK," or trust--learning to trust myself, trusting my instincts, trusting my ideas, and stuff like that.

As Colleen indicated, the process of learning to trust oneself can be facilitated by a therapist who provides validation and encourages one to attend to one's inner experience and to trust that:

> She gave me constant feedback about things that I was saying. She gave me constant encouragement and

> validation in...everything I would bring to her, and that really helped me to trust my own perceptions, because, at that point, I wasn't trusting my own assessment of myself or anything. I always had to have somebody else's validation before what I experienced was real, and she always brought me back to what I was feeling, what was right for me, and made me see that I could trust that sense.

For Fiona, too, validation was important in developing trust in self. It was also important, however, to acknowledge the reality of the abuse to herself. For Fiona, acknowledging the abuse meant acknowledging her mother's inability to act out of love for her and to respond to Fiona's needs rather than her own. Developing trust in herself was, therefore, related to her ability to accept the consequences of acknowledging the abuse, as the following excerpt illustrates:

> Some of it has just been the whole process of starting to get it out and to talk about it and stuff. Some of it's been the validation from the family that I get, although most of that stuff does not seem to come up unless I push it. I think one of the biggest things that helped has been my decision to let go of my mom. That has probably been the biggest thing because it was like in order to maintain the fantasy of the relationship "my mom loves me" or "my mom's going to love me if I am a good enough daughter"--I think that I always denied--I could deny it, I could live in a fantasy,...I could continue playing the family role and if that cost me my self trust, well, that was just the price you pay.

Learning to Accept Self

Learning to accept oneself, as is, is, paradoxically, the basis for most change. Accepting self means learning to be less judgmental and more understanding of what one considers to be signs of weakness or inherent "badness." In concrete terms, that often means beginning to appreciate that one's behaviours, rather than being signs of weakness or "badness," have been the means by which the individual has been able to survive the trauma associated with the abuse.

Elizabeth, for example, talked about recognizing that her compulsive eating as a teenager was the one means at her disposal of maintaining a sense of power in relation to her father:

> I started eating when I was 12 or 13 and that became a whole ball of contention. That became a power struggle with my dad. It used to make him mad, so it was like "good." Here is one place....You want to see me shove food? Well...

Later, Elizabeth talked about the sense of sadness she had in recognizing that she, too, was abusing her body to feel some sense of power. However, the fact remains that the behaviour had survival value. It allowed her to feel some sense of control in a situation where there were very few opportunities to do so. It allowed her to continue to believe, on some level, that her actions made a difference, which is essential for change.

Coming to understand the dynamic underpinnings of various behaviours is obviously a process that continues throughout therapy. What participants described as important, however, is the communication of the message that there is a reason for one's behaviour and that the behaviour serves a purpose; it has a positive function with respect to the self. For Fiona, that message had a powerful impact:

> I get into some really passive aggressive games, and I understand why I do...Ann said this to me once. She said something that I was doing, and I was really angry with myself when I saw what I was doing. I was just disgusted. And she said, "That's the way your little kid learned how to take care of herself, and maybe it doesn't work today, maybe it's not healthy, but when you look at

> it, you really are trying to love yourself," and that was like "wow." So I tend to remember that a lot of my behaviours, my reactions to things might not always be so great, but underneath it all, I am trying to hold myself, I am trying to take care of myself. And maybe it is not adequate, [but] what is important is that I am trying to care for myself and that's good to be recognizing that.

The other impediment to self-acceptance, in addition to present behaviours that are considered unacceptable, is self-blame related to the abuse. The communication of the message that the victim is not to blame is a crucial element in the development of self-acceptance. Stephen, for example, talked about the importance of his therapist's consistent message that he was not to blame:

> Nobody has ever stood there in my life before, day after day, and told me that it wasn't my fault and stuck by that. A lot of people said, "Well, you know, it's not your fault, but what did you do?".... What was I supposed to do when I was four? And when I was 15, it was...I was beaten severely...

The question of responsibility is a complex one that may continue as an issue in therapy, on different levels, for a long time, particularly when memories of the abuse have been repressed or dissociated. Often individuals believe themselves responsible because of particular actions or reactions on their part that need to examined and put in context. Not infrequently, victims have been blamed by the abuser or by others aware of the abuse. Those messages are often firmly planted, and retributing responsibility appropriately is generally a gradual process.

Similarily, developing the ability to accept oneself "as is" is a gradual process that has both instrumental and absolute value. That is, it is both an end in itself and a precondition, in some degree, to dealing with other issues. The ability to accept oneself is directly related to the level of acceptance demonstrated by others as more and more of what is considered shameful or unacceptable about self is revealed. One of the most important roles for a therapist in facilitating the development of self-acceptance is showing acceptance of the individual. Participants in the study talked about a number of ways in which their therapists were able to do that. Merry, for example, cited her therapist's "refusal to pathologize":

> The other day I saw Fern, and I said I had seen this Woody Allen movie, and it was sort of like my life, and that concerned me because he is so neurotic, and I said, "So, obviously, I am neurotic," and she absolutely refuses to pathologize: "You can use that word if you like, but...."

Heather described the same "refusal to pathologize" on the part of her therapist with respect to Heather's slashing of herself. She was also able to convey a sense of how a therapist shows acceptance of a behaviour that is destructive in its effect:

> Slashing is something that is quite scary for a lot of people to deal with, but it has been important for me to take that into therapy and work with it and know that Jill doesn't like it but is completely accepting of it as something that women learn to do--and learn to do in any number of ways--to slash even if they don't actually pick up a knife or whatever and cut themselves. There's some very complicated things happening there that are important; it's not just craziness or self-destructiveness.

What therapists are doing in conveying those messages is modeling, for clients, a non-judgmental stance which focuses on understanding--understanding the context and functions of behaviours and understanding the self. When clients are able to do that for themselves, then the basis for self-acceptance is there.

Summary

The degree to which therapy needs to focus on strengthening the self and building skills depends on the needs of the particular individual. Abuse affects individuals in many different ways for a variety of reasons. Characteristics of the individual such as intelligence or temperament may affect the response to abuse. The characteristics and dynamics of the abuse itself can influence the nature of the effects. Finally, the context in which the abuse occurs has an effect as well. For some individuals, the sexual abuse occurred in the context of other violence and neglect, and there were few opportunities for positive connection with anyone in childhood. In other cases, nonabusive emotional nurturance was provided, at least in some degree, by other family members or by individuals outside the family environment. Add to those factors a myriad of possible coping skills that may be learned by observation or discovered to be helpful by accident, and it is not difficult to understand how both the nature of the effects and the degree of psychological damage can be so variable.

Those differences mean that the emphasis on strengthening the individual will be more or less important and that the focus will also vary. For some individuals, the primary focus will be on recognizing resources, trusting self, and developing confidence. For others, there will be a need for more focus on the development of new skills. For others, the greatest need will be the development of some self-acceptance. In all cases, however, individuals need to be believe that they have, not only the support of another or others, but also the inner strength to begin the process of "reconnecting dissociated experience."

Participants in the study tended to talk about the ways in which their therapists facilitated the recognition and development of internal resources. It was also clear, however, that they were active participants in that process.

Actions that participants in the study described included setting time aside for reflection and introspection; "working" in therapy, for example, collaborating with the therapist to solve problems or understand one's behaviour; taking risks, however small, to act on one's own perceptions, follow one's own instincts, express one's feelings or state one's needs, and beginning to use the information acquired from those actions for learning purposes; taking steps to meet one's own needs and nurture self; and, using available sources of support or taking steps to expand sources of support. The more that individuals were able to undertake those kinds of actions, the more individuals were able to look at dissociated childhood experiences that continued to shape present behaviour.

Reconnecting Dissociated Experience

Much of the literature on working with survivors of childhood sexual abuse makes reference to the fact that some adult survivors, for at least some period of time, have no conscious memory of being abused in childhood. That was the case for more than half of the individuals who participated in this study. For the individuals who did have a memory of abuse in childhood, the memory was often devoid of any affective content. In Heather's words, "I had known for a while that I was a survivor, but there was no affect involved. It was just very abstract knowing."

Furthermore, in all of the cases where individuals did have memories of being abused as children or as adolescents, memories of other incidents of abuse, not previously remembered, were recovered in the process of therapy or with changes in life circumstances. Stephen, for example, found, in therapy, that "where you thought there was one, there were hundreds." Helene, similarily, said, "I had [memories of the abuse], but I had a lot less than I thought I had. I knew what had happened...I knew that some of it was gone or suppressed, but I was certainly very conscious of what had happened."

Helene had been out of therapy for nearly 15 years when she began getting flashbacks of being abused at a much younger age than she had previously remembered--the age, now, of her eldest son. For George, memories of his abuse as a boy similarily surfaced when his son reached the age at which he had been abused by his father:

> My first memory--sexual memory--of my father didn't occur until two years after I quit drinking. That's a year ago now. My son turned four last June, and I went nuts. I just felt extremely uneasy, and I remembered that, when I turned four, I was never allowed to hug or kiss my dad again. I was on a handshake basis. And, all of a sudden, I realized that was all wrong. That was when I had my first memory of experiencing incest from my father.

The process of recovering memories of childhood abuse described by participants in this study suggests that, in the face of experience that is too overwhelming to acknowledge, individuals will separate the various aspects of the experience, or fragment it, in order to handle it. In other words, cognitive knowledge may be separated from associated affect, sensation, or behavioural responses leading to a situation where "abstract knowing" exists, where inexplicable emotional states or behavioural responses occur, or where apparent visual, auditory, or tactile hallucinations are experienced.[1]

For any given individual, there may be a tendency toward a particular pattern of memory fragmentation. There may, however, also be intra-individual differences. Helene, for example, had no memory, for many years, of being sexually abused as a very young child, believing that her stepfather's sexual abuse began when she was about ten years old. Her experience, when she began having flashbacks of being abused as a very young child, was that the experience was "very chaotic, and mostly just feeling, not ideas." As she got older, she began to develop skills to contain the affect, and it no longer was necessary for her to dissociate the knowledge of the abuse in order to contain the affect:

> When I was older, I remember all sorts of mechanisms that I had for dealing with it, and I realize that, as a four and a half year old, I had none of those mechanisms....My most common mechanism would be to deaden myself emotionally and put myself in the corner--upper corner--of the room.

In other words, she learned to dissociate the affective component of the experience. Her description of separating mind and body also suggests that she learned to dissociate the sensory component of the experience. What is left is what Heather describes, in her experience, as an "abstract knowing" that one was abused without access to the affect and sensation that allow one to acknowledge the impact of the experience.

Beginning to Reconnect: The Impact

The impact of reconnecting dissociated experience and recovering memory can be enormous. For individuals who have had no conscious knowledge of their abuse, recovering those memories can create incredible turmoil. Elizabeth, for example, had no memory of her abuse as a child until her father's death, eight months into therapy:

> Up until that point, my life was perfect, and then, suddenly, it was shattering--shattering revelations...the family pictures being shattered, and who I am...my whole world was shattered.

Remembering the abuse means that one also needs to deal with related issues that may be difficult to face. Colleen, for example, indicated that it meant she had to deal with the reasons for her failure to tell anyone about her assault.

Contributing to the state of crisis associated with the challenge to one's world view is the memory recovery process itself. What the participants in the study described was a process where the number of fragments in awareness increased dramatically, once the door was open, if you will, as if to increase the probability that association would ensue. Unless the individual has a clear framework for understanding what is happening and some strategies for regulating the flashbacks, the experience may become overwhelming.

Memories of abuse or memory fragments appear to be triggered in the same way that all memories are triggered, that is, by some association with that memory or that memory fragment. A physical sensation may trigger memories of other physical sensations, hence the ability of sexual contact to trigger memories of abuse for many survivors. Situations provoking anxiety or fear or anger may be the trigger for retrieving memories of other situations provoking such feelings. Seeing oneself in one's children may trigger memories, and so on. It is also likely that memories of being abused will trigger more memories, as is suggested by Stephen's account of his "disorganized" thought processes at the outset of therapy:

> When I went in, my thoughts were so disorganized. I'd go from when I was three to fifteen and back to seven and back to--there was no direction in it.

For Diane, the process of becoming both more aware of her emotions and more open to expressing them in therapy appeared to open the door for the memories of her abuse as a child to surface. Those first memories, as she describes them, were fragments of her experience that began to intrude into her consciousness:

> A couple of months [after being in group therapy], I started getting memories. Little flashbacks and body memories and smells and hearing things that people said or noises that were associated with the abuse, but there

> weren't connected to anything today...ways that I had been touched that were really abusive--I would start feeling the sensation of being touched when there was nothing there.

Sometimes the memories would surface in dreams, as did her memory of being raped at the age of ten. Sometimes she would have images, "snapshots," of events. Sometimes she would experience intense feelings that seemed overwhelming. In response, Diane said:

> I basically fell apart....I stopped sleeping, eating--just basically became a zombie for about four months. It was mostly mass confusion. Part of what added to the confusion that I was feeling was that I was not sleeping. I would sleep for maybe an hour and then I would sometimes be awake again for 24 hours and then sleep again for a couple of hours and then be up again. I think the longest I slept at one time was about four hours. It was just nonstop. I was just so wound up and couldn't unwind. I was scared. I don't know that I have ever felt fear like that before, and I hope I never do again. That probably had a lot to do with it. I was terrified all the time. I was having nightmares, but that wasn't so much--I had nightmares when I was a kid and that never stopped me from sleeping. I think a lot of it was a lot of the emotions that I had pushed back that went along with the abuse were coming out and they are very painful and scary and really, really strong. There is some really powerful emotions involved...fear...pain, anger--anger so strong that I felt like I could kill. It was all really scary.

The sense of crisis that Diane reported was very common among the participants in the early stages of therapy, when memories of abuse were first surfacing. For Colleen, "things got really crazy for me...I was just a basket case." Stephen was afraid he was going crazy. George said the recollection of his father's abuse "left him spinning" for a year. Merry said:

> There was some days that I did not think I could function. I went to...[a] conference, and I felt like I was going to go mad at it....I really started to feel dysfunctional...but I think I did a lot of work that summer, and I continued...I continued to be able somehow to go to therapy...I don't know what I would have done without that. That has always been a great fear of mine, slipping into madness....I would spend [time] just crying and not wanting to see people--this outgoing extravert who just was always on the go--just closing off and not feeling like seeing people. And a lot of hate and anxiety...it all sort of bubbled to the surface, and it had to be dealt with.

As Heather said in the interview, part of what makes the flashbacks and feelings that surface so frightening is not understanding, because the flashbacks and the feelings are dissociated fragments, what they are about. In the beginning, there may not even be images that help one relate what is being experienced to a particular incident. For Elizabeth:

> It was just feelings [in the beginning]. That has to be the worst. Physical feelings. Anxiety. Feeling like I was going to die.

Sometimes, even when there are images, they are so fragmented that the individual is unable to make sense of them. When Helene first began to have flashbacks of being abused as a young girl, she simply had images of green pants in her face. Because she was conscious of her abuse at an older age, she had some sense that the images were related to the abuse. It was still some time, however, before she was able to access the memory of what happened.

Establishing a Framework for Understanding

When individuals have no framework for understanding what is happening, it is important that one be provided or created.

Sometimes a simple explanation will suffice. In Helene's case, although she was conscious of being abused as a girl, she had never had flashbacks before. Understanding that the images were flashbacks of her own experience, and that it was not uncommon for situations with one's own children to trigger memories, allowed her to understand what was happening to her. Once she had that understanding she was able to begin the process of integrating them, or, in her words, "structuring" them so that she could accept what happened and deal with it:

> Part of it [structuring the experience] is that--it's just accepting that there's a spirit side of you that's damaged and that you, as the adult, can find ways of taking care of the damage--that it's not damage to you as the adult and that you can structure--even something like making them sequential. When I first started having flashbacks, it was really just about these green pants that were in my face,...and I remember thinking, "at least it wasn't genital because that would be--then, of course, it became--I realized that it was genital. So just realizing that probably it started that way and that I'm experiencing the flashbacks probably in the sequence that...the way they happened to me. And so, if I can just look at them as ways of understanding what happened to me, then I'm structuring them, if you see what I mean--making some order and saying, OK, then, if you can get some kind of order and if you can recognize the damage, then you can create a structure about it that you can deal with as an adult.

Recognizing that one is experiencing memories of abuse, or fragments of memories, can have enormous impact. Without that recognition, it is easy to believe that one is losing one's sanity. Without that recognition, individuals may also assume that the thoughts or images or dreams that they are having are evidence of their own "sick" impulses, as Marianne did before she began to realize that many of her dreams were actually memories:

> Later on, I realized that all my life I had been having memories. It's just that I hadn't connected them as being memories. All I thought is they were just perverted dreams, but now I realize it was memories....Throughout my life, I had always had these nightmares, these sick sex dreams that I always thought was because I had a demented mind. I would always get these really horrible, just really bad dreams, and I always just thought that I was the person that was really sick. When I realized what it was from, it just made me feel so good.

When a framework for understanding one's experience has been established, then it becomes much easier for individuals to begin to identify the emergence of various kinds of memory fragments in consciousness. Several individuals, for example, talked about the particular quality of memory dreams. The following is Diane's description of the characteristics of such dreams:

> I would just keep having the same nightmare over and over again, and I would remember it with clarity the next day. Normally, if it's just a dream, you may remember it when you first wake up, but within half and hour it's faded. You know you had a dream. There may be some residual feelings left, but you don't really remember it all that well. These dreams would stay in my memory just as clear as day. Most of the time there would be no variance in the dream; it would be just exactly the same each time.

In the interview, Heather talked about learning to identify what she called "incest feelings," some of which were identified in dreams, others of which occurred in her interactions with others:

> I recognize transference with other women in my life--mostly my partner--either an intensity of feeling or

> feelings that are very inappropriate there or that are burdened with an excess of significance or...the emotions come to me in dreams. I'll wake up with a very specific feeling, but I know that there is a quality to the feeling that is different from having a dream about something insignificant. I know very specifically when I've dreamt and remembered a feeling that's an incest feeling.

Others learn to identify the signs of emerging memories. Fiona, for example, was able to identify a pattern that signalled the emergence of a memory:

> I knew when something was coming up. I knew when it was about to happen....I wouldn't sleep. First I would go through a period where I slept a lot, and then I wouldn't sleep at all. Nightmares. Scared to go to sleep. My eating. I would binge, or I would starve myself. I would go through periods being really, really paranoid, not trusting anybody. I would go through periods that I didn't like to be touched. I am really good about keeping a two foot wall around me. People don't usually invade my space when I don't want them to, and I don't have to do much to get that to happen. I would start to dissociate more--just sort of start to not be in contact with what was happening, starting to feel a lot of panic coming up. It would get to the point of being--feeling really panicked inside--just totally freaked out. I would almost have this image of a little kid, you know when little kids are just totally freaked and they are flapping their arms around...and they are just screaming and yelling....

In some cases, those "signs" may be the dissociated affect related to those memories which may surface in free-floating form or attach itself to an object in the present, as Elizabeth describes:

> I started out having major anxiety attacks before the memories just all the time, and then it abated, and then I would have them just before every major kind of push for a new memory--not even a new memory--a new theme coming out. First, I was terrified of choking, then I went through--gosh, I've had so many little phases--terrified of choking, of stopping breathing....When we had the tornado, I attached--I didn't have any experiences with tornadoes, but the tornado was, for me, the first time of having an experience of fear so intense that it even slightly matched what I had as a child, so it linked up a bunch of stuff, and it really symbolized for me--became a real outlet for just this complete fear of my whole world.

Gaining Control

Learning to identify memory fragments is important in giving individuals some feeling of control. If the experience is identified as the emergence of a memory fragment, then the person can take some action with respect to the experience. It allows the individual to say, "this is what this is, and this is what I need to do," as Elizabeth described when she said:

> "I know if I am going through stuff, there is something I need to do. I need to either write--I need to either draw--I need to get in touch with the memory. I need to share it. I need to get support with it.

The skills identified in "strengthening the self" are important at this stage because they allow individuals to take some control and to feel like they can handle what is happening. In that way, the context in which the fragments of past experience enter awareness is different from the original context where the individual needed to dissociate the elements of the experience in order to handle it. As confidence in one's ability to handle memories develops, two things happen. One, the sense of panic diminishes. Secondly, more and more of one's previous experience enters awareness or becomes part of conscious memory.

A number of participants expressed the belief that the subconscious acts to keep experience out of awareness until the individual is able to handle it. The memories of one's abuse do not surface all at once. Some specific memories may not surface until long after other memories have emerged. The degree of fragmentation may also lessen over time as individuals become better able to handle the impact of remembering abusive events, as was the case for Diane:

> [The memories don't come all at once, you get] only as much as you can handle at one time. A lot of the memories that I have had--especially at first--it would just come out in little bits and pieces. It would drag on for weeks, sometimes several months of body memories and images flashing in my head and feelings surfacing briefly and then going back down....As I have gotten stronger, I have been able to recognize when something is there and needs to come up, and then I can just sit down and just hug my teddy bear and say, "OK, tell me."

For participants who had been victims of ongoing abuse as children, there was a pattern of more and more intense or traumatic memories surfacing over time. In Elizabeth's case, for example, there was a progression involving recollection of increasingly intrusive abuse, followed by recollection of incidents that were more and more damaging to her on a psychological level:

> It started with remembering my father and then remembering the types--different episodes, different kinds of things--and then I had a flashback of my brother abusing me, but the interesting thing with that--I had one flashback, did a little bit of work, and then I didn't go back to it for a year and a half. It was so loaded for me that I don't think I could have handled it--then went back into that, and then I've been remembering

> lots and lots of deeper level stuff...more traumatic...and the picture that's evolving now--there is more than just incest per se...it's almost like a ritual abuse type of thing without having cult involvement...so [I] started to remember all the dynamics of that.

In addition to the pattern of recalling progressively more traumatic memories over time, participants also talked about a process that Heather described as "looping" in which one comes back to certain experiences at progressively deeper levels, each time understanding a little more deeply what that experience meant. In the following passage, Heather describes both phenomena:

> I know I am just working with more and more intense experiences....My sense of the work has been that it's been linear...in proportion to how devastating those experiences were...but, at the same time, there is somewhat of a looping, I think, that happens specifically in relation to things like feeling abandoned. I think there are various levels to that experience.

Elizabeth, similarily, talked about a process of "looping," that is, the gradual retrieval of information and the movement to a progressively deeper understanding of what the abuse involved and its impact in the following examples:

> Let me give you an example....I had tremendously low self esteem and...getting in touch with just the memories of how it felt to be abused and how being abused from my dad or my brother made me feel...ugly [helped me understand that]. Then, three weeks ago, I went through all this stuff around feeling ugly--it was like, "I've been there; I've dealt with that" and, for a long time, I was feeling really beautiful, but three weeks ago, suddenly what was coming back was memories about my father actually programming me, saying, "you're ugly."

Later, Elizabeth provided another example:

> I had my heaviest memory...at Christmas...and it got triggered because there was someone at work talking about suicide....I've never been suicidal although I had this real fear, for a year and half--terrified I was going to get suicidal. Suddenly, at Christmas, I had this flashback of my father threatening to kill me, and, again, I had had memories of him threatening to kill me before, which was one level of fear. Then, suddenly, it's not just threatening to kill me, but telling me how he was going to cut my wrists and put me in the bathtub, and everybody will think I committed suicide, so, again, it's almost--it's like getting half memories, and then getting the rest. And so, for the last six years, I keep getting new levels of information about the experience at the place I can handle it.

The retrieval of memories provides information to individuals that is important in terms of understanding self. The combination of the need for information and the need to regulate the impact of that information means that the pattern of memory retrieval may vary from individual to individual and over time. For some individuals, memories--particularly early in the process--are often embedded in dreams, perhaps, because, as Diane suggests, the impact is less immediate:

> If something happens that is so painful that you had to block it out, it has to be introduced into your conscious mind very gradually. That's the subconscious mind's way of introducing some things--it comes out in a dream. You may wake up upset, but it doesn't come at you all at once.

In dreams, memory retrieval may be gradual in the sense that Marianne described in the following excerpt:

> Each time I have this particular nightmare, it seems like I see one more thing...[for example], I'll see the room I am in more specifically. I still haven't really put that one together, but I just feel that, in time, when I

> am ready, I will, one day, be able to follow through and get the rest of it. I feel [the dream] is [connected to a memory], but I still don't know where it is, or when it happened, or how old I was, but I have had quite a few memories that are visual. When I used to have these really awful sex dreams, it was always somebody doing something to me from behind. Sometimes it was so real. It was like a person that was doing something to me, but there was never a face--sometimes I'd see the hands. Now, I have had several memories with the visual--the person that was doing this to me--and it's just like I'm there and it's happening to me. Sometimes, I get the feeling of what's happening to me, but I really don't have my emotional feelings connected to those memories yet.

Dreams also provide opportunities for information to be disguised in some sense, that is, available for access if the individual chooses to work with the dream, or not, if the individual seeks not to do so. Dreams provide an avenue for expression, as do art and dance, that does not require an individual to rely solely on words to communicate. That is particularly important where there have been strong injunctions against talking about the abuse, as was the case for Colleen:

> It was through...working with the dreams, that we came to a lot of stuff....It seemed like that was where I was able to speak from. I wasn't able to put things together and articulate them in an ordinary every day kind of way. Even things that I knew had happened, I couldn't just speak about in a straight forward kind of way because it was very threatening, but it would come out anyway through dreams.

Seeking Reconnection

Learning to appreciate one's memories as "information," and believing that one has the support and the internal strength to "handle" the memories, means that one's relationship to those memories changes. They no longer are simply a source of pain to be avoided if possible. That difference was expressed by participants in a number of ways. Colleen, for example, expressed in words the change of attitude that she experienced:

> In a way, I almost welcome those times when it [the past] comes back to me, because I do know things that I can do for myself in that, and I do need that knowledge. I do need to know what happened back then, and I want all my feelings. I want--I think that's basically it--I want to remember. I didn't remember for a lot of years, and having those memories and having them make sense and having the things in my life that did not make any sense for so many years, having it make sense is just this incredible gift.

For others, the difference was expressed in terms of behaviour rather than in words. In some cases, individuals simply provided opportunities for memories to surface by ensuring that there were times for reflection. Marianne, for example, talked about a memory surfacing because she provided the opportunity for that to happen:

> A lot of times I lay in bed in the morning when I wake up because I wake up usually quite early, and I lay there and think about things. One morning I had a flash, and I think I was just a baby. I might have been nine or ten months old because, you know, a baby is flapping their hands and you don't have real motor skills yet, and, all of a sudden, I realized that I am this baby, and there is a penis in my face, and I am playing with it like it's a toy.

In other cases, that difference was expressed in terms of the individual taking active steps to reconnect dissociated memory fragments rather than attempting to ignore or suppress the information that was surfacing. Actively taking steps to reconnect the memory occurred in various forms. Diane, for example, described training herself, at the suggestion of her counsellor, to pay attention to her dreams and the feelings associated with them:

> The counsellor I was seeing told me to start paying attention to [my dreams], to write them down or just pay attention to them, because there was something to them. It may be clouded in symbolism because it's a dream, but there was some truth to it....[I started] just by paying attention to dreams that stayed with me...and keeping track of what feelings came up. If I woke up shaking and scared, just to make a mental note of that and just kind of attach it to the dream, and eventually there would be a memory surface that would be related to the dream.

Participants also described using particular techniques such as journalling or hypnosis to access information from dreams. In the following example, Colleen describes how she and her therapist worked with a dream she had and, in the process, retrieved a memory of being assaulted as a young girl by a friend's father:

> [In the dream] I was going to the folk festival with my daughter who was about four at the time...and I dreamt that I got picked up by this guy in a car and I was sitting in the front and she was sitting in the back seat and that he pulled over in this place and had decided that he was going to rape me...I had the key to the car and I had to decide at one point whether I was going to use the keys to try and blind him or not and get out of the car but I was worried about the little girl in the back seat--about my daughter.
>
> When I brought this dream to Fern, she suggested that perhaps the little girl in the back seat was me and not [my daughter]. Then I went home, and I had the dream again...and discovered that it was, in fact, me, and the crisis went a little bit further, and he started to

> attack me, and it was at that point that I could smell this smell. There was a very vivid strong smell for me and the crisis of what do I do with the keys....Then we did a trance in which we went back to that smell and accessed that smell, and it turned out to be the key to a memory. I had been attacked when I was nine by a friend's father and [in] her house there was--that day there was this very strong smell from the dog who had an ear infection, and so I recalled the incident almost completely under hypnosis with the access that that smell memory gave me.

Focus on and/or intensification of sensations present in "body memories" may also facilitate recall of other aspects of that memory. Many of Elizabeth's memories, for example, had a clearly identifiable sensory component that was sometimes the point of access to information about her abuse as a child. In the following passage, she describes both some specific body memories that she experienced as well as the more general physiological effects of being in a stressful environment:

> The body memories that I have ongoing would be memories of suddenly being touched. Suddenly, I'd get these weird kind of feelings...exactly as if someone is touching me or doing something to me....When I was going through certain stages--there were times when my dad used to tie me up and I'd get burning wrists for ages--that kind of thing. Then there's also body memories of just generic stored pain--all the things that weren't specific events....Sometimes I think, for me anyways, I stored everything...it's like when someone stands and shouts at you, you hold it in somewhere and it becomes a pain place, so there's that as well--just a releasing where there's not a specific memory.

Massage therapy became an integral part of Elizabeth's healing because it helped to counter the sense of disconnection that she felt from her body. Beginning to develop a relationship with her body meant learning to become aware of the body's ways of communicating. For Elizabeth, it meant that she had another tool for understanding self.

Focusing on feelings and permitting their expression is another means by which participants were able to access memories of childhood abuse. Heather indicated, for example, that when she allowed her feelings to surface and be expressed, there was often "information" associated with the feeling:

> Within the last few years, I've decided that even if I don't ever know where they came from, the most important thing to do at the time is give vent to the feelings and let them come and have as much space--I mean, if I need to spend three hours crying, then, you know, whatever--and usually there's information that's associated when I let it just come out.

For many of the participants, writing was a tool for expressing feelings that facilitated retrieval of memories. For others, memories were accessed when feelings were expressed in drawings or paintings. Sometimes the physical expression of emotion (e.g., pounding a bed) would facilitate memory retrieval as well as providing a sense of release.

Participants also talked about more deliberate strategies to "trace" feelings such as the use of hypnotic age regression or techniques designed to facilitate association. Heather, for example, talked about how she sometimes works with "incest feelings" that surface in dreams or interactions with others:

> So then I try to trace them or spend some time writing with them or sort or rewrite the dream to see what comes up, to try various scenarios with the feeling, because the feelings come up, but they are not connected with the actual context that they were generated in so they sort of desperately search this world now for a context. There was an artist...named Pirandello...who wrote a story about six characters in search of a script...the

> characters were characters out of a play...searching around for a script to enter into and, in some ways, it's very similar to that. The feelings are there and they are not connected to where they belong, and part of my work is to reconnect them as close as I can. Take them out of this context, and say they don't belong there, they come from some place else....I think there are stories that are waiting for a context to emerge in, and I think if I can sit down and have enough time to create a context in writing, that information comes to me.

Trusting One's Memory: Acknowledging the Abuse

In order to actively work with the fragments of memory to facilitate reconnection, individuals must learn not to discount or ignore the feelings or sensations or images or thoughts that surface. Therapists can help clients in that regard by encouraging attention and by validation. Elizabeth, for example, described how her therapist encouraged her in that process:

> A lot of times what would happen is I'd have a memory and I'd have the weirdest things come into my head and then I'd go into therapy and say, "well...but I'm sure it's not a memory," and Jill would say, "well, let's see," and I'd say, "that's ridiculous" and "I don't see the point." So it would start with that little flash, whatever it might be, and then go from there and go deeper and deeper.

For Elizabeth, her therapist's encouragement to explore her experience and to validate it were very important, as was her presence as a witness to what had happened:

> That has been one important thing throughout...hearing a consistent voice of "yes, it's true, trust it"....Every time I had a memory--and it's funny how profound this is for me...I'd have a memory and I have somewhere to take it and someone to sit with me and help me validate myself...

Merry, similarily, talked about the importance of her therapist's encouragement to pay attention to her dreams and her validation that, for many, memories first surface in dreams:

> I started remembering mostly through dreams....[Fern's response to those dreams was] that a lot of women do their most important work in dreams. So again, it was just getting the message that this is a valid experience, this is your valid experience.

That validation may also come, indirectly, from others. Fiona, for example, talked about the importance of family members validating her perception of family dynamics. For Marianne, validation from family members that images she had from childhood were related to actual events helped her to accept that the images of being abused that emerged as flashbacks had a basis in reality also:

> For a while I kept seeing brush piles, and I thought, "Why am I seeing these piles of brush?" and I just couldn't understand this. And then I asked my brother about it. I was just talking to one of my brothers, and I just asked him about brush piles. I said, "What were we ever doing around the farm around brush piles?" and then he told me. He said that when we lived on the farm, they were clearing the land, and he said we used to have a tent, and my mom would pitch this tent, and they would go out, and while mom and dad were clearing brush they would leave us in the tent--the kids--to play....and he said that we, the kids, were mostly around the tent and that would explain why I would see the brush piles. I must have been just a baby at the time.

For individuals who have learned to keep information out of awareness as a means of coping, doubts about the reality of memories that surface, particularly when the memories first surface in dreams or in fragmented form, can be triggered even after the individual has been in therapy for years. Elizabeth, for example, remarked:

> My first memory was one of my father abusing me--one episode--and that took a lot of time for me to even get to a place of even believing it. It took months...and, even now [six years later], I think it's an ongoing struggle. I don't know if this is common for everyone, but I think it probably is for women who have repressed anyway. There is still a place, "Is this really real?"

Merry, too, talked about the sense of self-doubt that surfaces for her from time to time:

> Still at times, when it gets really rough, I'll say--I'll sit down and I'll say, "Are you making this up? Is this being made up? Is this something because you have read something?" But usually I am validated in some way--a real clear memory or a dream or something.

Sometimes the reality of one's abuse is difficult to accept because of what that means, as the following passage from the interview with Fiona illustrates:

> When I started having memories of...the abuse [from] my grandpa...I had a very tough time with that. In some ways, it was harder than the stuff with my mom....I was having a hard time with accepting that it was [abuse], that it happened, because I always needed to believe that my grandpa really loved me.

Sometimes the reality of one's abuse is difficult to accept because it means acknowledging emotions that are threatening to one's sense of self, as Diane's comments illustrate:

> With my father, I had to go through remembering several things in order to start realizing just exactly, honestly and truly, how I felt about him....In order for me to come to some kind of resolution, I had to not only remember, but I had to take a look at exactly how I felt about him and the fact that I really didn't like him very much....That can be really threatening and very painful

> to realize. There is a little child in all of us that will always need our parents ....[It was difficult to acknowledge] just how angry I was with him and how much I hated him, despised him, for the way he was treating me. Those feelings have always been there; it is just I have never acknowledged them.

Acknowledging the reality of one's abuse also means being open to its emotional impact. In Diane's words:

> The emotions need to be faced squarely...to be vented in some way....That can be the hardest part because the feelings are so--when they first come out--are so overwhelming and so powerful. I've felt more than once like I was drowning...when I was in the middle of it....Unless you've been through it, you can't know the intensity of the emotion that's involved and just how devastating it can feel to realize fully the fact that the people who were responsible for you being born are the very ones who hurt you and hurt you so bad....It's taken a long time for me to wade through all of the abuse that I have been through and get down to that little almost newborn baby that felt abandoned completely by both mother and father. I felt no bond at all.

Changing the Context: Changing the Experience

Because the intensity of the emotions associated with the abuse can be overwhelming, it is important not only that individuals feel the support of others, but also that, to some degree, they are able to find what Stephen called "the balance point between here and not being here." In other words, individuals must be able in some way to maintain some distance from the experience of abuse while remembering it and being open to its impact. For many, that means being able to remember what happened as child at the same time that one remembers that one is no longer that child. Heather, for example, talked about beginning to face the overwhelming feelings of abandonment that she had as a child that continued to affect her relationships in the present:

> My mom did take off and it was very--it was awful, [but], instead of constantly transferring that fear--those feelings...it's having the feelings and facing the abandonment--that she did leave and left us with my grandfather. It's a very tricky thing because certainly those feelings couldn't have been expressed at the time, as a child, but they can be expressed now. It's kind of cheating in some ways in the sense that I know I work very hard when I am having those feelings to also have a sense of myself as an adult so that both of those things can be there at the same time. So I have feelings of being abandoned, but I know that I am not...facing the world completely alone.

In other words, as suggested previously, the context in which the experience is recalled is different from the context in which the experience occurred and, as a result, the experience is capable of being altered in the present. That is, I believe, what Elizabeth means when she talks about "healing the memories":

> Going back and healing the memories [is important]. I really firmly believe...within our own inner worlds there is no time. Whatever has happened to us is here and now. So to be able to go back--until we do some kind of change to those memories, they stay impacting us as victims.

For Elizabeth, that work meant having her adult self enter the experience to "rescue the little girl" or, before she felt strong enough to that, having her therapist enter the experience to speak to the child or to the father. Few of the participants talked about working with memories in that way; however, in every case where the surfacing of memories was seen as part of the healing process, the context in which childhood experience was recalled was much different from the context in which the experience occurred.

The Positive Side

As painful as the process of retrieving memories of abuse can be, for many of the participants, there were positive benefits that they did not anticipate. As Stephen said:

> One of the things that I've been surprised at [is] that there were a fair amount of good memories of my childhood, but when you block out the bad ones, you block them all out. As I've been trying to work through the bad ones, the good ones have come forth and gone, "We've always been here, but you never gave us a chance to shine."

In addition, when one has had very little memory of one's childhood, there is often a sense of disconnection from self and from others. Marianne, for example, talked about the "warm feeling" that came from remembering her childhood and the contrast with the feeling that, had it not been for school, she would have had no sense of "where I came in the stream of time." Fiona's description of her experience of the aftermath of a period of retrieving painful memories speaks also to the sense of connection with self that comes with acknowledging one's past:

> I would feel very tired but kind of peaceful in a way....There was a sort of a sense of "you can't touch me"...it was very strange, safe almost....It would just seem like there was a renewed sense of self or something...that cocoon thing was a very nice safe feeling, and it would almost be serene...for awhile, even though there would be pain, there would be emotional pain...sadness, but it was sort of OK.

The process of recovering memory and reconnecting with one's experience was described by all the participants as important in healing. As difficult and as painful as that process often was, it gave individuals a sense of connection with self, and it gave them the information they needed to evaluate their understanding of self and their expectations of others.

Understanding Differently

The reconnection of dissociated experience is important in allowing individuals to understand both their past and their present differently. Understanding differently is important in developing self-acceptance, in learning to separate past and present, and in seeing new possibilities and different choices for oneself.

Understanding differently is dependent upon having access to one's past experience as that experience is the raw data used in the construction of meaning. Secondly, understanding differently is dependent upon the existence of a different context in which experience (past and present) can be examined. The meaning of any experience is context-dependent; when the experience is located in a different context, its meaning changes as the accounts of participants in this study show.

Changing the nature of the interpersonal relationship within which the experience is shared is one way in which context can be changed. An interpersonal context in which acceptance, caring, and respect are conveyed in response to experiences in childhood and to current behaviours has the potential to shift understanding. Perhaps most importantly, it has the potential to offer an alternate view to the belief that one was (and continues to be) a "bad" person.

The context is also changed by the presentation of other information and other perspectives. For example, the proposition that there is a connection between how one reacts or operates in the present and the kinds of coping skills learned as a child provides a different framework for understanding the present. Similarily, the idea that behaviours serve a function provides a different framework for understanding those behaviours. Information about the prevalence of child sexual abuse or physiological responses to sexual stimulation or child development can also change one's understanding, as can different perspectives about what is appropriate treatment of children or who holds responsibility when children are abused. All of those ideas have the potential to shift understanding in a way that allows change to occur.

Understanding the Past Differently

One of the most important changes in terms of understanding the past focuses on the issue of blame and responsibility. A sense of responsibility for the abuse is often a strong part of a survivor's belief system, and re-attributing responsibility for abuse may be a lengthy process. In Diane's words: "It was years before I started feeling like this isn't my crime; it's somebody else's."

Part of that shift comes from the consistent message that one was not to blame. For Diane, hearing someone else say that she was not to blame was an essential first step: "At first, it takes somebody else doing that for you." In order to begin the process of seeing differently, she needed to hear a new perspective. Often, that message is one that needs to be repeated and repeated in different contexts. For Stephen, the fact that his therapist "stood there...day after day...and told me that it wasn't my fault" was important in helping him to begin to believe that he was not to blame.

As important as hearing the words is, that in itself is usually not enough to shift beliefs that developed out of one's experience as a child. As Stephen said:

> I can say..."I didn't deserve what happened to me," but believing it has been a lot tougher. I don't know if I still do. I try to, and I know that I should and I can and it's OK, but I don't always succeed even now.

For many individuals, the retrieval of specific memories of the abuse is helpful in providing information that allows the individual to understand the experience from the perspective of an adult. Helene, for example, found that re-experiencing the sense of fear and powerlessness that she had as a young girl helped her to understand the situation differently:

> What she [therapist] made me do is go back to being ten when I thought the abuse had started and basically experience being abused which was really, really awful--I just had no idea how awful it had been, if that makes sense--but what I realized doing that, was that, as a ten year old, I had absolutely no power, that there was nothing I could have done, physically, emotionally...I had nothing, compared to or proportionate to what was being done to me, and that was really the turning point in therapy...recognizing the difference between myself and that ten year old girl and realizing that there was absolutely nothing I could have done.

For Diane, that same recognition of herself as a victim allowed her to accept that "it wasn't my fault, I was a victim, I was a child, I had no control of the situation" and to move beyond being a victim. Recognizing oneself as a victim, however, means allowing oneself to be open to the pain and the fear and the sense of powerless associated with being a victim. In Diane's words:

> Part of what happens when you suppress something that happened is a little part of you stays at that age; at least that seems like that's the way it has felt for me. If I was abused at three years old, then the part, a little part of me, would stay three years old and not move on, not grow up. The only way to really get at that part of you and heal that part of you...to embrace that part of you and say you were a victim, you were hurt, and it wasn't your fault--the only way to do that is to face it squarely and say, "Yeah, this is how I feel--I am damn angry about it, and it hurts like hell, and I didn't deserve [it]."

In some cases, the retrieval of memories provides individuals with information that helps them to shift their feelings and their understanding. For Stephen, remembering an incident of being held under water to force compliance with the abuse allowed him to see both that he had resisted at one time, which was important for him, and to understand the development of the belief that resistance would result only in further harm. That understanding, together with an examination of the choices he had in the situation, was important for him in understanding his reaction as a teenager when he was abducted and raped by a gang of men. It was important because remembering that he did say no at one time allowed him to believe that he *could*. That recognition then freed him to look at the reality of the situation he was in as a teenager:

> Now I talk about it--I can tell you what happened--many of the things that happened...from the beatings to being forced, as a 15 year old boy, to commit or be part of group sex with men, bestiality, being bound and gagged and tied over kitchen chairs, or hooded and beaten, or being laughed at, or [they] told me that it was actually what I wanted or I was starting to enjoy it because I was [reacting]. Every time I would become compliant or unreactionary...they would do something else, they would try something new. That's where the bestiality came in--"well, we'll see what this does"--it was control....With Maureen [therapist] is the first time I ever brought up the fact of the dog...it was and is...one of the toughest memories that I have to deal with...it's pretty tough to get much more disgusting than forcing any person to have sex with an animal--grown men standing in the background laughing.

What is important, both in understanding the effect of that experience and in helping to facilitate healing, is understanding Stephen's reaction to that rape. What he felt was "degraded" and "ashamed--that if only I would have fought harder or better or stronger or faster that it wouldn't have happened." That sense of responsibility, which exists on some level for all survivors, is perhaps particularly difficult in a cultural context that sees men as masters of their own destiny: "Real men" are strong and powerful; "real men" are not victims. For healing to occur, the victimization needs to be acknowledged, as Diane suggested, and therapists need to challenge the beliefs about responsibility. That means attributing responsibility to the offender(s); it means realistically evaluating the options that the individual had; and, it means helping the individual to understand the extent of his or her resources, given his or her age, emotional state, and history.

Acknowledging one's victimization means accepting that one was powerless and without control. For many, that is difficult because of the sense of vulnerability that follows from that. Realistically evaluating the situation and one's resources in that situation is important on a meta-level because it says that one's responses are a function of situation. In other words, there is no necessary connection being a victim in the past and being a victim in the present or in the future.

In general, understanding the past differently is related to having access to one's feelings as a child. When those feelings are experienced and acknowledged, the reality of one's life as a child may be understood very differently, as George's story illustrates:

> I sort of imagined my childhood to be this wonderful thing. We got to do lots of things, and I grew up in a quite a wealthy home--we had lots of money. I had a season's pass to Lake Louise for my whole life and got a car when I turned 16. I had lots of things. I grew up in a very materialistically above average environment. And I also realize [now], that's all I had.

Similarily, Marianne talked about the kind of "fantasy" beliefs about parents that are sometimes created in childhood as a defense against the pain of not having one's needs met as a child:

> I guess because you never got to have a proper childhood, you still have this fantasy idea that these are the people that really love you and really care for you and, as a child, you don't see the reality, you just pretend. In the reality, I realize now when I look back, I realize just the day-to-day neglect on the part of my mother....Now I can see that I really wasn't parented by parents that really cared about us because any parent that was caring wouldn't send his three children to spend a week-end with some old bachelor that was known to be a kinky kind of man.

Acknowledging the reality of one's childhood and holding one's parents responsible for abuse or neglect experienced at their hands does not necessarily mean lack of understanding or even compassion for one's parents at some point in the process. Diane, for example, talked about moving past her initial denial of the abuse she experienced from her parents, through acknowledging the pain associated with that abuse, to being able to see parents as human beings with their own pain:

> One of the things that starts happening toward the end of the healing process that I have gone through, especially with family members, is I start being able to see them as very sick human beings instead of just somebody who hurt me. I start being able to see a little of where they are coming from.

Therapists play many different roles in facilitating changes in understanding the past. Providing a safe, supportive environment where feelings can be experienced and the reality of one's situation explored is one. Providing a different perspective regarding the abuse is another. Thirdly, therapists, by their encouragement of new behaviours in the present, can provide opportunities for a new understanding of the past. Merry's decision to try to talk with her mother about what was happening for her in therapy demonstrates very clearly how a new behaviour in the present can shift one's understanding of the past:

> My mom and I were having a before-dinner drink and...my palms were actually sweating because I was so uptight because I was going to tell her about being in therapy and that I had been working very hard at it, and I was very, very nervous. But I did tell her...and she looked at me and said, "What time are you meeting [mother-in-law] downtown? To her credit, a little while later she asked me...who I was seeing, but she just can't...too dangerous, I think. There's a sort of glaze that comes over her....It has explained so much to me because I used to be so upset--I mean why can't this family talk about anything real? Any time I would try and talk to her about anything, even before I was aware of the sexual abuse, it was--we would get onto how much money something cost. Money has been a big focus, and it never made any sense to me until this surfaced. So that's helpful. It makes me feel, "well, no, you're not crazy."

Seeing one's parents or significant others differently and seeing one's situation differently allows one to have a better understanding of one's own reactions. Marianne, for example, was able to understand her depression as a child. Colleen was able to understand her inability to tell her mother about the assault perpetrated by a friend's father. Elizabeth was able to understand overeating to spite her father. George was able to begin to understand his own sexual acting out. Heather was able to understand her feelings of responsibility for her mother and her siblings. In all these cases, the responses to the abuse were related to patterns of behaviour in the present. Understanding the past differently was, then, a necessary step in being able to understand the present differently.

Understanding Connections Between Past and Present

Central to understanding the present differently is recognizing that present behaviours are understandable in the context of one's history. That understanding is important for several reasons. It facilitates the development of self-acceptance, and it allows one to begin to separate past and present. The result is the creation of a situation in which the generation of new responses becomes a possibility.

Self-acceptance comes from being able to see that one's emotional reactions and behaviours are understandable. Stephen, for example, described how learning to see the connections between situations in the present and the past led him to be more accepting of self:

> The house that [my girlfriend] and I had was on 25 acres and had a big old barn and an old two storey house. I grew up on the farm--it was someplace I always wanted to be--and it was as soon as we moved into the place, we started to fight, and I couldn't figure out why....I started to get picky about stupid things...and then it's when I started having the very physical, violent nightmares.... For me it was a turning point. So many times in my life, I had come up to that wall....[Maureen would] help me make sense of all these things that have always been, in my life,...such triggers for me....The farm was very much a trigger for me. [My girlfriend] was going through some things with her family at the time--disclosure, confrontation--and it was just a constant trigger and so it kept me off balance. All of my life it's a feeling I've always had...I'm the outsider--just off balance--always having to try harder and work harder or be better. And nobody had ever helped me connect it before. It's easy once you draw the picture--it's easy

> to see what's there--but when it's just a bunch of dots on a board, you don't know what it is.

Self-acceptance is also what allows an individual to look at one's own behaviours. Seeing oneself as able to act and make choices, both of which are necessary for change, means acknowledging that one's current choices may not be healthy. Self-acceptance means having the ability to honestly acknowledge one's own undesirable actions without destroying all sense of self as a worthwhile human being. For Diane, as for others in the study, that sense of self-acceptance allowed her to look at the abusive behaviours she had internalized:

> I'm starting to accept myself a little more--I still have got quite a ways to go on that--but I am starting to now take a look at ways that I behave toward myself that have been, or are, self abusive and starting to think, "Well, I don't think it's a good idea for me to keep doing this, and it might be a good idea to change it." It has been a bit difficult for me to look at that. I found myself going through quite a bit of guilt at first. I have been so angry at other people for abusing me, and I have been abusing myself, too. But, logically, when you think about that, that's all that I have ever known. What else am I going to do? I think the main thing in that is the fact that I am starting to care about myself enough that I am even willing to look at it.

Self acceptance allows the individual to look at one's own behaviours honestly for the purpose, not of judging, but of understanding. In many cases, as Diane suggested, the behaviours that one shows are the behaviours that one learned as a child because that is all that was modeled. In other cases, the behaviours had "survival value" in the context of that individual's situation as a child. George, for example, came to understand his abuse of alcohol in that way and, in doing so, was able to become more accepting of himself:

> I am an alcoholic, and that saved my life--I also know that. My brother shot himself when he was 20. I know why people could kill themselves. I had lots of reasons, and it was a gift that I discovered alcoholism when I was 13. It did keep me alive; I believe that strongly. It wasn't maybe the most healthy way to protect myself, but it worked awful damn good, and I would still be drinking if it worked. It just quit working. The disease marched on. It quit working for me. I didn't have that great feeling; I didn't feel like the life of the party. I felt like shit. [But] it gave me some time. I remember doing some sculpting work with a lady whose son shot his head off when he was 22. He was just like me.

Individuals deal with pain in many ways. In some cases, they turn to alcohol and drugs, as both George and Fiona did. In other cases, they turn to food to deaden some of the pain, as Elizabeth and Diane, for example, both did. In other cases, as for George, compulsive sex becomes another way of distancing one's feelings. Others isolate themselves, physically and/or emotionally, or use denial or dissociation to avoid pain.

All of those strategies have consequences that need to be acknowledged and owned. Elizabeth, for example, talked about the sadness she sometimes feels about how, by overeating to goad her father, she has used her body to feel some sense of power in her relationship with her father:

> It's almost like my body became a bit of a pawn in many ways, not only of my father's, but also of mine. And I've had to go through looking at that, and...there's times when I say, "Look at what I've done to my body." It just breaks my heart.

In the same way, George talked about having to accept the consequences of his behaviours and the sadness associated with choices that were made:

> I lost a lot of relationships because I was either passed out, drunk, or because I just wanted to be sexual...I didn't understand anything about intimacy and having a conversation related to someone, trying to connect with their feelings. I have a lot of sadness now as I'm into my recovery. I have a lot of sadness about my whole life.

Accepting the consequences of one's actions can be difficult. For George, it meant, among other things, acknowledging the people he had hurt. It meant being open with his wife of eleven years about his behaviours and taking the risk that the marriage would be able to survive:

> The biggest risk of all the things I had to hand over to my higher power was hand over my marriage. If it was meant to be--and it might not heal. I don't know. I don't know, and that really saddens me [to know that's a possibility]--a very real possibility. It's a pretty big wound. Probably 20, 25 affairs, prostitution, this crossing gender stuff. She had a pretty hard time with all that. Married to an alcoholic....

For several participants, understanding the extent to which denial and repression were used to cope with one's own pain meant recognizing that they were less able to recognize the signs of abuse of their own children and accepting that reality. In Merry's words:

> It's too bad that I had everything blocked for so long because I think my daughters have experienced it. It's great that we are together and that we love each other and that we are all working very hard..., but, on the other hand, I had to deal with a lot of guilt...if I had known, if I had been aware [of my own experience]...I haven't got a doubt [that I would have been more able to see what was happening with them]....I went through all the usual things like hammering myself and wishing I had known. I had many times alone where I was very upset

> with myself. Then, like "give myself a break." I obviously had become very skilful [at keeping things out of awareness] for good reason. So I just don't think I am as hard on myself as I used to be.

As Marianne began to recognize the connection between her depression and nightmares and her abuse as a child, she began to recognize signs of sexual abuse in her own children and she, too, needed to deal with her feelings about her inability to protect them:

> I know my kids have been through abuse, and I feel they have been victimized by my father. One of my sons has had some memories. My youngest son had, for years and years, terrible nightmares--really, really horrible nightmares--and my father would say, "Oh, it's because of what he is watching on television." When my son started having the nightmares, we didn't even own a television....It wasn't until I started dealing with this issue [that I] recognized why he was having the nightmares....That's another thing that I felt really bad [about]...that I didn't protect my children and it's--I realize that I can't change things there. It's like I was living in denial, and I couldn't do enough to protect my children....Now, at least they are aware...and they can, at least, protect their children if and when they have some.

Acceptance means acknowledging the possibility that one's ways of coping have resulted in harm to another. However, it also means recognizing that one did the best that one was able to do given one's resources at the time. It means recognizing that behaviours have often developed as a means of coping, that they serve a purpose. Recognizing the positive intention in the behaviour is central to self-acceptance. It is also the first step in the identification of alternate behaviours, alternate ways of addressing the needs that one has, as Heather's account of her slashing suggests:

> At some point, I recognized the space of mine that I move in when I want to slash....The actual point of wanting to slash...doesn't last for a long time, so I know that if I can somehow divert that energy or that need onto something else or displace it onto something else, then I can prevent it from happening....If [I can] get through that [time] then the feeling will just dissipate, and then I won't particularly want to [slash]....At the same time, understanding, not just the build up to it, but there's something that occurs after the slashing happens that's really important to my sense of being able to take care of--not being able to take care of myself--but of taking care of the wound....It's a self-nurturing kind of a thing. So I have had to find ways of getting that without having to create an injury first....It's a long process of transferring that into another activity that will generate the same intensity of comfort.

Understanding the function of a behaviour requires the ability to recognize the underlying emotions and needs that give rise to that behaviour. For survivors, it is not uncommon for situations or objects in the present to trigger some aspect of a memory, often the associated affect. In order for the individual to look at what alternatives exist in the present, it is necessary for the individual to separate past and present. That means being able to recognize the transfer of dissociated affect, for example, to the present situation and then distinguishing what is associated with the present and what is associated with the past. Over time, the more that dissociated memory fragments become reassociated, the less the present is contaminated by the past. That, however, is an ongoing process to which there is perhaps no complete end. What is important, in terms of the healing process, is that the individual develops the skills to make that separation when needed in order to deal more flexibly with situations in the present.

The first step in the process of separating past and present is being able to identify those situations where past and present are connected, where elements of the current situation are triggering memory fragments and beliefs associated with one's abuse as a child. Elizabeth, for example, described her need to understand the source of feelings, such as fear, in order to be able to separate past and present:

> It was really important for me with some areas [to understand the connection with the abuse]. Some I didn't need to, but the real critical ones I needed to understand where it came from first. The fear of being alone--it was so important for me to understand that because then, when I was going through terror, I could go, "Yeah, I know why," and I could validate it...then I could reassure myself..."you don't have to be afraid anymore; you had good reason to be then; it's safe now."

For Stephen, understanding the source of his anger and being able to separate what was related to the past and what was related to the present also meant changes in how he responded to situations in the present:

> When I get frightened, I get--outwardly, I get aggressive and angry....Learning where that anger comes from and putting it in the right places...allocating the right emotions, if you will, on the right memories, to the right places instead of becoming angry now because my son gets 40 on his math report card. I can be angry at that, but the anger is [different]; it's not the end of the world.

Similarily, understanding the source of beliefs that one holds about self in the present may allow individuals to begin to see themselves differently. George's longstanding belief that he was "too short" and the associated negative connotations of that for him are a clear example of how an experience in the past can colour one's beliefs about self:

> My son turned four last June....That was when I had my first memory of experiencing incest from my father....It started off with--a body memory was my first recollection. I felt like I just had a pressure in my pelvis, and then that became like a watermelon on my pelvis, and then it became a head....I was in a shower. I got blamed for being--it was my fault because I was too short--and I got this penis in my mouth....I believe I told my mom. She says, "Oh, no. I was just obsessed with being short," but I realize now with my kids, they don't give a damn about how tall they are....My kids...really trigger me. I become aware of a lot of things that were not right in my childhood, and I didn't know that until I had my own children at those different developmental places....My kids don't worry about how tall they are...it's not part of their consciousness.

Separating past and present means reassociating dissociated affect or beliefs with their source. It may also mean testing the validity of particular beliefs, for example, in the present. Understanding the source of one's beliefs may open the door to questions about the validity of those beliefs and to actions that will test and challenge those beliefs. Helene, for example, talked about the importance of recognizing that doubts about her own abilities were connected to her stepfather's ongoing denigration of her abilities. Recognizing that connection, coupled with her desire, as she says, to say "fuck you" in whatever way she was capable of doing, allowed her to take a step that was clearly, for her, such a test:

> I left home at 16, dropped out of school, had only a Grade 10 education,...[and] I realized I wasn't going to get anywhere without an education as a woman--just anywhere--I just had dead-end job after dead-end job--and I decided I would go to university....My stepfather imbued both of us [brother and self] with a powerful

> sense of our own stupidity and inability to do anything, so that was such a major step for me to say [I am going to go to university] and realize that the feelings about my own inabilities to do this were not about what I could do or could not do but about what he told me I could or could not do.

For Helene, challenging that message meant being able to acknowledge the feelings that made the decision to go to university difficult and being able to identify the source of those feelings. Individuals may not, however, be able to identify beliefs that influence their behaviours and their choices until they are able to access the affective context in which that belief developed. Making that connection allows the individual to place that belief in a particular context and reverse the process of generalization that has occurred, as Elizabeth's story about the gifts that follow the pain of remembering illustrates so powerfully:

> I always get a gift; it's like I come out the other side when I go through particularly intense periods, for example, the memories about my father [threatening to kill me and arranging it to appear as if I committed suicide]...it's so agonizing to remember the pain of having a parent who would go to such a degree...and having to feel that pain, as the child, of being--and this was actually a very significant part of the memory. It was at that point, as nutso as it may seem, that I really got "I didn't matter." For the previous 11 years or whatever it was, I always sort of thought, "It's still--I'm still in here somewhere," no matter what he was doing to me, and it was at that moment, when he said that, I suddenly really got "I don't matter at all." So the incredible pain of that--that's so overwhelming--but I know that once I move through it, there is always something on the other side, even if it's the realization of "yes, I do--that was one person's opinion."

That kind of shift in understanding has enormous potential for changing other beliefs, for changing behaviours, and for changing one's emotional state. Not all shifts are that dramatic. Many, however, allow the individual to consider new possibilities or make changes in various aspects of one's life. One area of primary importance is with respect to one's relationships with others. For Heather, as an example, the ability to understand her fears about abandonment differently allowed her to make different choices in her relationships with others. The distinction that she was able to make between fearing abandonment and fearing the experience of feeling abandoned is an indication of such a change in understanding:

> The anxiety that I would have in relation to my partner is not that she is going to abandon me, but that those feelings are going to escape from their place of containment. I mean, it's already happened....The thing that hasn't happened is...there hasn't been an experience of those feelings. So, I don't think that I ever really worried that somebody right now is going to abandon me. I think, looking back on it,...I was more afraid of those feelings being let loose, rather than the person actually abandoning me, so, finally, at some point,...I just gave vent to them...and it does open up options....I am at a point of realizing, for the first time in my life, that if I don't want to be in a relationship that I can be the one to say this isn't working for me any more and initiate it in that direction.

Therapists can facilitate the process of making connections between past and present and understanding differently in a number of ways. One is helping clients to identify triggers in the present. In some cases, that means first helping clients to link particular emotional reactions or behaviours to events in the present. For Marianne, her therapist's questions about how she was feeling and what had been happening to her helped her to begin to identify triggers. Secondly, it means helping clients to look for connections with the past. That can occur in any one of a number of ways. It may involve techniques for "tracing" feelings or physical reactions, for example, or it may involve therapist interpretation. In many cases, therapist interpretation is simply making an observation about similarities between a situation in the present and a situation in the past. Colleen, for example, talked about how the presentation of possible connections between past and present by her therapist allowed her to become more sensitive to triggers:

> She put things into a broader perspective very often....She would make a lot of connections between different incidents in my life or suggest the possibility of things, and then I would see that that was or was not the case. It wasn't that she had the answers, and I found them from her. It was more that she would take what I had presented, and she would remark on certain things. She would say, "that looks very similar to what happened here," and, all of a sudden, there would be clicks, and I would go, "yeah," and it would come together for me. She was very insightful in that way, and I think that, in that way, I was able to carry on that process myself a lot of times.

Simply creating a frame that posits a connection between past experience and present state often allows individuals to start making connections for themselves. As Colleen suggests, once that possibility is created, one begins to think in those terms and to become more skilful at making connections on one's own. Although therapists often have an important role in helping clients make particular connections, the creation of the frame can occur in other ways as well. One of the benefits of "bibliotherapy," for example, is that the published stories of other survivors invariably talk about the connections between past and present.

Understanding the present differently involves being able to see the connections with the past in order that one can understand the history and context for emotional reactions and behaviours in the present. Paradoxically, making that connection with the past is what allows one to begin to separate past and present and creates the opportunity for new possibilities to be entertained. Making the connection allows one to understand that particular responses or behaviours have a function, a positive intent, whose form is shaped by the nature of one's past experience. Often, therapist "reframes" simply make such connections explicit, as the following example provided by Elizabeth illustrates:

> In my first sexuality group, one of the facilitators said to me--again, a beautiful way of reframing....It was the first place where I told someone I was a virgin because I was so ashamed....She said to me, "wow." She said, "I think you have done a wonderful job of taking care of yourself, of not getting into relationships when you knew you couldn't handle it or for whatever reason it wasn't safe"....It's like, "Oh, that's it--that [is] what I was doing."

Separating past and present requires the ability to see that the present is different from the past. In particular, it means appreciating that one has support and resources that one did not have in the past which is why the development of connections with others and the identification and development of internal resources are so important for change. The ability to see the present as different from the past is what opens the door for the consideration of new possibilities. When therapists distinguish between past and present for clients and help them to recognize the differences, they facilitate the development of that ability. The process is one that requires individuals to be attentive to instances where past and present are not distinguished and, as Helene suggests, it is one that requires practice:

> I think that it's really important to make it [the abuse] a past thing and that what's happening to you now is present and you are a different person. You are not that person, and what happens to you now is not going to have the impact on you that it had then. You have the tools and you have the resources and you have the strength that you didn't have then....[That] was just something that I realized as I kept going. I would say [to myself] that "you don't have to feel like that 10 year old because you know this now. You know how to walk now, you know how to get out, you know you can get out, you know you have all of these skills, you have all of these smarts, and you have all of this emotional wherewithal, and it's just really practice.

Seeing New Possibilities

Seeing new possibilities for one's life and seeing new possibilities in terms of one's behaviour is often the prelude to making changes. Change is always difficult, however, because it involves stepping into the unknown, doing what one has not done before and what was often unsafe to have done at other points in one's life. In order to begin to consider new possibilities, one has to let go of the past in a sense. One has to let go of one's reliance on behaviours and ways of being that had survival value. Those behaviours and ways of being are, however, part of one's sense of identity, and letting go often means reconstructing one's sense of identity. For Stephen, that recognition was important:

> In The Courage to Heal--the workshop book that I did--it asked me if I healed what would I have to give up, and I said, surprisingly enough, my past....It's been the only thing that I have had. Everything, throughout especially my childhood, was ripped away from me, if you will, so, even as bad as the memories or the actions were, they

> were mine, and, if I gave them up, then what would I have? Who would I be?

In recognizing the obstacle, Stephen was able to deal with it and take the risk to discover who else he might be. Similarly, Helene talked about the difficulty in leaving behind the person one has been, not yet knowing who one will become:

> [There is a] point that I think everybody gets to in therapy where you've really grown. This person inside you who is the person of the abuse, the creature of the abuse...that creature gets less and less powerful, and then what you have...is a great big black hole in the middle of you, and I think that it's the scariest moment in therapy. It's terrifying. And then you have to decide whether the creature of the abuse is going to control your life, or whether you are going to build somebody else in there...somebody that you really like....probably one of the toughest things I have ever done was to recreate myself...because you look into nothingness, because you are not sure of anything about who you are. If you give up the creature of the abuse, then who do you have?

A number of participants talked about taking that step in terms of death and rebirth. Colleen's gift to herself in a trance experience was an evergreen cone that grows only after destruction by fire. For Merry, similar images emerged in her dreams during the course of therapy:

> I've had several dreams in which I die, and those have been almost like turning points in the therapeutic process....In all of them I have the power to come back....[It's a dream about rebirth but it's also] a death in a way. I have done a lot of grieving....The first one I had,...I had to say, "No, I'm not ready yet. I don't really want to die"....I think probably the dying is the old--the old reactions, the old ways of being...

Perhaps the first step in seeing new possibilities is the recognition that change is possible, that one no longer has to continue to do what one has done, to say as Diane did: "Well, I don't think it's a good idea for me to keep doing this, and it might be a good idea to change it." Diane, for example, talked about "rejecting the scapegoat role" that had been hers in her family or origin from early childhood. George talked about stopping compulsive sexual behaviours that were becoming, increasingly, a source of shame. Merry talked about recognizing her role as the "motherly one," the nurturer of others as a choice. In each case, the focus is on stopping behaviours that are seen as destructive or unhealthy or limiting.

However, people do not simply *stop* behaviours that have a function for the individual or the system of which an individual is a part. The behaviours need to be replaced with something else. What is central in that process is being able to envisage an alternative. George, for example, talked about what he would like to be able to do when he began to become aware of a feeling, rather than avoiding the feeling:

> How I envisage what I would like to be able to do is one of two things....feel comfortable enough in this conversation to say, "Fine, I'm just going to sit with this for a second, and I'll cry for a bit, or I'll rage, or I'll scream, or I'll do whatever it takes" or...[to] say, "No, I don't feel particularly safe with you right now, I'll get back to you later" and I'll book a time.

Elizabeth described the importance of being able to visualize a possibility, "being able to visualize that I can do it or that it can change," in making change. For her, the first step in exploring the possibility of having an intimate relationship with another person was starting to think about it and trying to see herself in that situation. In the process of allowing herself to consider that possibility, she began to focus on issues related to sexuality that needed to be addressed to make the prospect of involvement in a relationship less frightening. Rather than work through those issues in the context of a relationship, Elizabeth began to do so in the context of the possibility of a relationship. In so doing, she was able to imagine particular issues that might arise and begin to identify ways that she might handle difficulties associated with being in a relationship.

New possibilities are created by new information. In some cases, therapists provide new information by simply presenting new possibilities. As Fiona suggests, in the following passage, one's own experience base may be limited, and, sometimes, what is needed is the presentation of another possible interpretation or another possible response:

> [What I need now, in therapy, is] a lot of direction...I didn't get a lot of direction or guidance in terms of what's OK or not OK in terms of...relationships, behaviours, what you do when....I can recognize the feelings but I don't necessarily know a healthy way to deal with it....A lot of times, I have just one experience to draw from and that wasn't a really good one...sometimes it's just a matter of a practical way to look at something....If somebody can say to me a different way to look at something or a different way to think about something, I can adapt very easily to that, but it's almost as if I don't even have the awareness that there are other ways to look at things....That comes out in my relationships a lot.

As Fiona also indicates, therapists are not the only sources of such information. As one becomes increasingly aware that there are many possibilities, one's attention can be directed to how people respond in many different situations. That may mean looking for opportunities to talk with others about interpersonal relationships or approaches to problems and so on.

It may also mean looking for opportunities to actively observe others, as Fiona talked about doing:

> I have certain ideas based on a little kid who saw my parents and said "this is bad" and "this is bad" and "this is bad" so when I see other people with these things in their relationships and they are still together, I get very confused and I ask a lot of questions....[What do you do when you are angry with people or] is it OK to sleep in separate beds? To me, that was a sign of divorce....I have a friend who is in a relationship, and they argue, and they argue when I am there--nothing really major, but I find it totally fascinating. Part of me is terrified, but part of me is really like "Wow, are they going to talk to each other now?"...[it] sometimes feels like there is a little kid there.

"New information" may also be in the form of distinctions that have not previously been made, as well as in the presentation of new possibilities, as Elizabeth's comments about how she began to learn to become more assertive illustrate:

> ...struggling with what I want and what I feel like I have to do--have to's, should's versus want to's--and learning that I don't have to do anything....It's, again, being taught....A lot of this stuff, I can remember going, "new information"...these "ah hahs," these continual "I never knew, it never occurred to me."

In some cases, new possibilities are related to a shift in perspective or a new way of seeing rather than to "new information" as such. Colleen, for example, described how a different view of "boundaries" allowed her to begin to explore the ground between having no boundaries or setting no limits and erecting walls to establish some distance from others:

> I am also remembering one of the trances that Fern did with me where she talked about boundaries. She used a

> wonderful image for me that really communicated to me that they were kind of imperceptible, that they could be very invisible. For some reason that was really important to me that you didn't have to walk around with a suit of armour on, that they weren't walls. She was talking about a forest, on the edge of a forest, on the tree line, and how it really just sort of blends in, and that was very effective for me.

Sometimes providing a new perspective is associated with "reframing" a behaviour or state of mind in some way. Both Marianne and Stephen, for example, described how the provision of a time frame altered their understanding. For Marianne, the reframe of her depression as a "bad day" acknowledged her feelings in the moment at the same time as it created the possibility for a different reality the following day. Similarily, for Stephen, the message that one's present state is not necessarily permanent and the normalization of such periods of time allowed for the possibility of change in the future:

> So many of my thoughts Maureen would take and just give it a little twist at the end, [for example], not wanting to have sex with [my partner]. It's OK. Lots of people go through that in their life. It's not like you are alone in that feeling. When you want to have sex again, you'll want to have sex again....It's not a big deal.

In some cases, new information and new possibilities are generated by one's own actions. Helene, for example, talked about feeling lucky to be a young woman at a time when there was little stigma attached to being sexually active because she needed that experience in order to see that sex was not necessarily "bad":

> I was again lucky. I did all this horribly attached acting out sexually, and then got into my 20's and was acting out and having a good time...it did take me a long time to be monogamous....It was luck because, you see, I

> had gone from this horribly repressed--sexual horror--and just re-enacting it, and I was extraordinarily passive, and then ended up being sexually active in a time where you could experiment and you could find out...so the experience was different...[My partner] and I have a really good sex life...and I think it was just that period where I could experiment and, again, say "what do I *want* sexually" rather than being told what's happening to me or it being imposed on me....This sounds really awful, but I don't think without a real variety of sexual partners that would have happened.

What is central to the shift that Helene describes is that her sexual experiences in her 20's were not perceived as abusive and that she felt in control of them. Were that not the case, the experiences would have reinforced the view of sex she had developed as a young girl rather than offering a new perspective.

Helene's experience is interesting because it points to the need for experiences to have the potential for an outcome different from outcomes in the past. Diane's experience of returning to school as an adult was another instance of an action that provided the opportunity for old beliefs to be challenged and new possibilities to be entertained:

> As far as my beliefs about myself, I thought I was unlovable, unlikable. I was treated like I was stupid for most of my life....I believed that I was stupid. It was not until I went back to school as an adult, particularly in English class--I started getting marks that were around 55, 60, 65, and I went "Oh, wow, I can actually get something above a 40"....and I know, now, that I am not stupid.

Had Diane returned to school at a point where she did not have the resources to attend and to focus on her studies, the experience would have reinforced her belief about her own stupidity. Where the experience challenges old beliefs, however, it opens the door to new possibilities.

Perhaps the most dramatic effects follow from a challenge to the belief that one is unlovable or undeserving of good treatment. As Helene says, "if you go into a situation where you feel like you are not going to be treated well, then it's pretty clear you won't [be]." Where the expectation exists that one will be treated well, then a situation in which that does not occur is clearly identified as one that requires change. For Helene, that gave her the power to say to her partner that the relationship needed to change or it needed to end. When one begins to be able to say, as Merry did, that "I am entitled to alone-time, I am entitled to set real clear boundaries, no matter what the relationship, and I am entitled to my anger", then the possibility of making those demands in a relationship emerges.

Seldom do new possibilities emerge in full-blown form. In most cases, the possibility begins as a glimmer that, nourished, begins to grow. As Stephen says in the following passage, the process is a slow, gradual one and, sometimes, the specific ideas that begin the shift are not momentous:

> It's something that Maureen has done so slowly....Some of it...I don't even recall, it was just so gradual...the ideas that she would instill in me, or she'd leave me with a thought until the next time we met...and it's actually been able to put a seed in there and it's growing...that I'm not bad, that I am OK, that I can smile, that I can touch and that I can be touched, that I can trust people, and that I can feel good about myself.

What is momentous, as Elizabeth suggests, are the consequences of beginning to see the world and oneself differently:

> You know, it's funny--I don't know if you've ever experienced this, but words and ideas plant in your head. You start to look at things differently. You haven't

> necessarily even bought into it, but it's the very idea, it's a new way, and then, suddenly, it's a new world. [It's a new possibility] and, by having that, the world has suddenly reorganized itself and it looks very different.

It is that shift that opens the door for changes in the way that individuals live their lives.

Making Changes

Making changes involves seeing new possibilities for oneself and one's actions and, then, being willing to take the risk to do something differently. In some instances, simply seeing a new possibility results in a change in behaviour. In other cases, however, individuals see the possibility of doing something differently long before they are able to risk doing so. In those cases, the role of the therapist is to provide support. That support may be working with the individual to understand what is standing in the way of taking that step and, then, addressing that problem. It may be simply the suggestion that the action will come when the client is ready to accept responsibility for the consequences of the action.

Often, particular changes become focal points in therapy because of the destructive nature of particular behaviours. In understanding the healing process, however, it is perhaps more useful to see the endpoint of therapy as the development of the *ability* to make changes in one's life as needed or as desired. In many respects, the most destructive aspect of abuse is the way in which it undermines the ability of individuals to explore possibilities and to risk different behaviours.

When participants talked about therapist behaviours that facilitated making changes, what was most important were the behaviours that encouraged exploration and provided support. In Colleen's words:

> In the beginning, I really needed somebody to trust, and then, after a while, I needed somebody to push me a

> little bit to take a few steps, to take a few risks, and then I needed somebody to listen very intently and to validate the steps I was taking. There were times when I needed a cheerleader, and there were times when I just needed a lot of support. Other times, I'll be a little bit lost, and I'll be looking for some feedback, some input in terms of where I can go from here.

Therapists encourage exploration in large part by helping to identify new possibilities. The identification of new possibilities occurs in an increasingly deliberate fashion on the part of clients as therapy progresses. Many of the participants in the study talked about using their therapist to see situations from a different perspective or to help them generate new responses, as Fiona describes in the following passage:

> I am in this situation where I just had a friendship--I've known her for about a year and a half, and it got to the point where I had to let go of the relationship. [I talked to Ann, and I said], "How do I let go of this relationship in a healthy way? How do I let go of it without it being you're this, you're this, you're this, or, I'm this, this, this, and this? How do I let go of it in a way that allows us both to deal with whatever feelings we have and doesn't make it about who we are because it's not what it's about? It's about taking care of ourselves and that's the reason why we can't be friends any more because we are just not good for each other. And how do I make that something that says I am not bad?" Because, that's what I would normally do with it. So, there is a lot of that kind of thing, of just learning to do things....[or] sometimes I just need an opinion or an outlook or a perception. [Someone to say, "This is how I would handle it"] or "Gee, you heard this about what that person said, but I heard this" or "Maybe this is what this means"....If...somebody doesn't call

> me, it's a rejection, and I get all freaked out because I don't know how to deal with them. I don't know what to do when I see them. Do I say hello? Do I ignore them? Do I pretend that nothing is wrong?...That's a really small thing,...but it happens, [and it's important].

Perhaps most important at this stage in therapy, however, is the provision of support. The base of that support is the clear communication of acceptance of the individual regardless of the changes that he or she makes. That acceptance provides support because it allows the individual the opportunity to "fail" without putting the relationship at risk. Where that is not communicated, clients can find themselves in difficult situations as Diane's comments about counsellors who had difficulty accepting her weight illustrate:

> For me, it just put me in an impossible situation. I am enough of a people pleaser that I felt guilty that I couldn't please them and do what they wanted, and, at the same time, I had this horrible need inside me to keep shovelling food into my mouth.

Acknowledging the difficulty of change and communicating a willingness to continue working with an individual to solve problems regardless of the time that takes is another way in which support is communicated. Heather, for example, talked about the sense of patience that her therapist communicated and the importance of that support:

> It was really important for me with Jill to just say, "Well, OK, we'll start again and work this through," so there's a sense of patience. There's a recognition that this is not--these are, in my case, 20 year old patterns...and they just don't go away because someone says you should take care of yourself in other ways.

Support means "being there" in a number of ways. As Colleen indicated, it means being available to listen and to validate. It means clearly communicating the belief that the person can make the changes that he or she wishes to make, as Colleen suggests below:

> Fern has been there for me through the whole process and really helped me to deal with things at my own pace and one at a time...and she's really kept me focused on how strong I am and has been able to remind me of the resources that I have already discovered and the strengths I have discovered in myself.

Support also means providing practical assistance at times. That may mean, as Colleen indicated, helping one focus on one problem at a time. It may mean providing feedback when requested. It may mean helping deal with the fallout that inevitably follows change. As Elizabeth indicated, becoming more assertive may be important for one's psychological well-being; however, it doesn't necessarily make one's life easier. Support may mean providing information when needed, or helping individuals normalize the anxieties associated with making changes. Elizabeth, for example, talked about how important it was for her to understand that anxiety about entering a relationship was not an uncommon experience:

> One thing...[that] was very comforting for me was to find out--because I don't know, I haven't been there--but Jill said, "Every time you start a new relationship, it's like starting brand new again. It's not like you get to be this seasoned expert and stroll into the next one." She said, "Every new one--unsureness--and all the kind of fear and anxiety that you think you are going to have, everybody has when they enter a new one," which was really reassuring for me to hear that.

In all of those kinds of ways, therapists can help clients to begin to take steps to construct their lives differently, to make change. In the final analysis, however, the step has to be taken by the person who wants the change, and, at some points, taking those steps will feel like a risk, sometimes of gigantic proportion. Participants in the study were often very aware and very conscious of taking risks in order to effect change. Diane, for example, in talking about the changes she has made, said:

> ...and, I take risks. They may not seem like big risks to other people, but, for me, they are....Three summers ago, I went on a camping trip. I have been in boats before, but I had never paddled a canoe before--well, that wasn't the first time. The first time I did, I was so panic- stricken...I didn't stay in very long. But the next time, on this camping trip that I went on a couple of years ago, I just decided that this fear of water was not going to interfere with my having fun, so I got into the canoe, and I said, "I am going to do this." For me, that was a really big thing....One of the ways this guy tried to kill me when I was 11 was to try and drown me. He knocked me out and threw me in the water, and I've had a real terror of falling into the lake...ever since then, and a canoe is not a very stable vessel. There isn't really that much room and distance between you and the water. It felt pretty scary. Just things like that. They may seem small, but inside it was big.

The ability to realistically assess risks and to face one's fears, to act despite the fear, is essential for change. Being abused as a child is an experience that elicits fear, often on both a physical level and psychological level. One of the strongest emotions described by participants when talking about the effects of being abused was the state of fear or terror that was associated with the abuse. One of the ways of coping with those feelings is to avoid, as much as possible, situations that may trigger those feelings. Doing so, however, means that one limits one's life in many ways. That is, in acting to avoid fear, one may also miss experiences that have the potential to be positive, growth-enhancing kinds of experiences. Learning to separate the past and the present is essential for evaluating risk in the present. No new experience is without risk, however, and, at some point, what becomes necessary is taking the risk and facing the fear. As Elizabeth says in the following story, taking that step is important in learning to live one's life differently:

> I went whale watching a year ago in April. I went with my sister, and we couldn't get on a big boat. We ended up taking a little Zodiak hard-hull inflatable out in the ocean...I was convinced I was going to die. It was my first time out on the ocean, let alone open ocean [in a little vessel]...the water's right there...ten foot waves. I really thought I was going to die, and then, it was the most fabulous experience of my life....That was a big turning point for me because it was like being faced with--I had all these vague fears about dying, and I didn't, and it was fine, so, a turning point in terms of "feel the fear and do it anyways" kind of consciousness. Simply because I am afraid doesn't mean that it's not OK.

Taking risks occurs on many levels, in many different contexts. In some cases, it means taking a risk to challenge an old belief or taking a risk to test the extent to which one has really made changes. In those cases, the risk is that one may fail in the attempt to do things differently. For Fiona, that risk was clearly present in her attempt to face her fears and act differently in a job situation:

> One outside thing...was my starting work. I had always--I had a zillion jobs, and I usually quit before I got fired. I had a bad attitude...I hated people and nobody--wasn't pleasant to work with--I don't know--wasn't good anyway. So after--it took all this time for recovery...and I did some upgrading and then started at NAIT, so I hadn't been at work for a long time. So when I started work...I was relatively calm when I started which was a real surprise...[but] I had a big fear that

> I was going to screw it up, that I may be able to hold it together for a little while and do an OK job, but I would eventually screw it up...I have been there four months; I have another two months to go; so far I haven't really screwed it up; it's going reasonably well....I got my evaluation after a month; they had nothing negative on there...I did excellent on all accounts.

For many individuals, making changes involves taking risks to change one's patterns of behaviour vis-a-vis relationships. Abuse occurs in the context of relationships and it is here, often, that change is both most difficult and most important, as Heather suggests below:

> I think learning to deal with other people in my life and not completely give up any sense of my self or what the work is that I have to do [has been the most difficult for me]....I've always had a sense of being alone in that that's the safest, that's the easiest, in the sense that I feel more in control that way, but the biggest work that I have had to do, the most challenging work, anyways, is in relationships, dealing with the kind of issues that get triggered in my relationships with other people.

All of the participants in the study talked about the impact of being abused on the development of relationships with others and about the changes they had made and were making in their relationships and in the ways in which they interacted with others. For some individuals that meant allowing relationships to develop. Heather, for example, talked about having "to really work at reintegrating some people back in my life." Stephen also talked about learning to reach out to others rather than "withdrawing [which] has always been my biggest defense mechanism." For Diane, healing meant "allowing people to start caring, not just me caring about other people--I've always cared about other people--but allowing other people to care about me without driving them away, learning to trust, learning what healthy trust is." For Elizabeth, healing meant considering the possibility of a relationship with a man, particularly a relationship that might be sexual.

For other individuals, changes were focused more on changing patterns of interaction. For George, for example, that meant learning not to sexualize relationships. For Helene, it meant learning to identify and express feelings, particularly anger, in her relationships, and to ask for time and space to do that. For Merry it meant learning to set limits and to find a "new balance" between trusting and not trusting others:

> Before...I was everybody's friend....Now, I am getting--it's a transition I have to go through. I think it's very wise for people to assess situations and be aware of what can and can't happen, and I have taken it very carefully in my relationship with Jane....It's almost like I don't know who the real me is yet; that is still evolving. Because, yes, there is a real extraverty part of me...loving to be with people and open, but there's a part of me that's "no way...watch your step." Maybe it's more balanced, but I have to get more used to it.

For individuals with ongoing intimate relationships, making changes often puts that relationship at risk. In some cases, the relationship improves, as did Marianne's relationship with her husband. In the following excerpt, Marianne describes some of the changes in her working relationship with her husband and business partner:

> Our working relationship is much better just because I stood up for myself and I am taking care of myself, and it's even better for him, too, I think...if you don't stand up for yourself, other people don't really respect you either. I think a lot of the things that he takes out on me are just anger that he is carrying over something, and I'm just the closest one to take it out

> on, and so I just told him, "I'm tired of taking your anger. If you don't want to deal with it,..." I said, "just don't take it out on me." So, now he is really changing, too.

When individuals begin to make changes, existing relationships are always affected, and, there is always the risk that the couple will not be able to make the changes necessary to make the relationship a healthy one that meets the needs of both partners. That is a risk that George, for example, clearly identified when he made the decision to be honest with his wife, knowing, as he said, that the marriage "might not heal." In many respects, the most difficult task is to change the patterns of interaction that have developed in the relationship, as George's story illustrates:

> I have a lot of confusion...in my relationship with my wife. We've been asexual for 15 months or so. It's very difficult. I find that very difficult. I'm also aware that it's my sex addict that finds it difficult. Now we're working on having a relationship of some sort which we never really had....My wife has an incredible amount of rage, for good reason. If your husband sat down today and said, "By the way, I've had 20 affairs in the last ten years," you'd be pissed off--more than likely....That's putting words in your mouth, but I suspect you might be pissed off and angry and rageful, and you'll say..."Well, why are you still with the guy?" She gets asked the same question all the time, doesn't know the answer sometimes. Part of it's relationship addiction, I suspect, and part of it's tied into she thinks she loves me, whatever that means. On some levels, she sees parts of me that are healthier, nicer than I do sometimes....The part that makes me sad...I can feel her love sometimes, and it's so hard for me to let that in. "If you love me, you'll hurt me." I just hate that fucking rule....[Sometimes] I get tired of being the

> "designated patient." I don't believe my wife came from as healthy a place as she leads me to believe...people chose people unconsciously...at some level, I also know that she's a survivor because she lived with me, and I have a lot of sadness around that...all the manipulation and control and her prostituting herself so she could...keep the relationship together....She's got to own where all that stuff came from--that's her stuff--because, at some level, she did have choices, too.

For many of the participants in the study, making changes meant beginning to evaluate their relationships, evaluating their own behaviour in relationships, and making decisions about relationships that were abusive or unhealthy or that no longer met one's needs. Colleen, for example, was very clear about that process:

> I started to make a lot of decisions about my friendships. There were very good friendships in my life, and there were some that were very abusive, and I started to really draw lines. I started to talk to people about behaviours that I didn't like, and I even left a couple of friendships telling people why that this was not OK for me that this go on and [that] things had soured and I was cutting out. And that was quite amazing because I had never, never done that before. I had always either set things up so that the person would get out of my life or sabotaged things in some way to get rid of them, but I'd never just stopped it and drawn my own limits. And I also discovered, if I did that, that the sky wasn't going to fall, that even if I drew--if I put limits on things within the relationships I wanted to keep that they weren't going to abandon me--nobody was necessarily going to abandon me. So it gave me a lot of power in relationships in deciding what was OK for me and what was wrong.

Similarily, Elizabeth talked about having to come to terms with "letting go of some old relationships...that don't serve who I am now," specifically, the sense of loss and the acceptance that change does involve loss as well as growth.

In addition to making decisions about relationships with partners and friends, individuals often have to make decisions about their relationships with their families of origin. Where those relationships continue to be abusive, that means taking steps to stop the abuse, where possible. Diane, for example, talked about her recognition that she needed to stop accepting the role of scapegoat in her family and take some action to change the nature of her relationships with family members:

> I finally just said, "No, the abuse has to stop." My older sister is still very abusive towards me in a lot of ways and so is my mother and so are other members of my family....My older sister--the way we have related to each other for so many years is by arguing, and it is something that has always really ripped me up inside because I hate it; it hurts....What I really want from her is some kindness and gentleness and some acceptance, and arguing with her and fighting with her is not getting that. So, I finally put a stop to it before Christmas. When she started trying to provoke an argument, I hung up on her. She was angry with me, justifiably. I would be angry, too, if somebody hung up on me. I didn't join my family for Christmas, and she brought my presents back...with her....I waited for about three or four days...and suddenly realized, "she's going to hang on to them; she's angry with me." So I called up a friend and said, "Would you drive me over there? I want to go and pick them up." That is something that I have never done before....Her way of remaining in control of me is to manipulate situations like that, to show me who is boss....I just called her up and said, "I have a ride.

> When are you going to be home? I am coming to pick them up." I got an "Oh"--very surprised. She wasn't expecting it, and, by the time I went to pick them up, she was almost apologetic...So, I am starting to [do things differently].

In many instances, trying to change the patterns of interaction with members of one's family of origin means dealing with the denial that often surrounds abusive behaviours. In some cases, because of changes in the family, individuals are able to change the nature of their relationships with family members. Elizabeth, for example, talked about the relationship she was able to establish with her mother following her father's death:

> My mom...was a real support, as much as she could be. When I first disclosed, she just got up and hugged me and has never backed away from that, but my mom has really coped through denial...so, as I did my recovery work, she, oftentimes, would be in denial, but, in a way, that was really good for me because it reinforced what it must have been like as a child. Now, the interesting thing is my mom's been in therapy and, then, she, too, is a completely different person. And I guess I am lucky...we've talked. And my mom's clear enough. She says, "Well, I was a different person then." She still goes through her remorse and guilt, but her having a clear conception of that--I can be really angry with who she was then...because I'm really not angry at her here and now, and she's conscious of that, so it keeps our relationship pretty open.

Similarily, Stephen talked about being able to establish a relationship with his mother, in part because of her change in circumstances, and the importance of that for him. For Stephen, that reconnection with his mother allowed him both to better understand his mother's actions when he was a child and to express the feelings he had about her actions:

> [Part of the healing has been making] amends with my mother. When I first started in this, I told her, I says, "You know, I am going to need your help." I says, "I am going to have to be asking--" and I have put some pretty tough questions forth to my mother. If you don't mind my language, I asked her on the phone one day, I said, "What fucking right did you have to leave me in the house with my father who's an alcoholic?" He used to beat her and beat the kids as well. I said, "What--you didn't care about me or what?" I also knew why. My father had told her that if she tried to take the boys...my brother and I...that he'd see us dead first or he'd see her dead first or both. But it's still a question that I had longed to ask her all my life. "What right did you have to leave me there?"

More often, however, individuals are not as lucky as Elizabeth and Stephen in establishing a connection with family members that allows them to deal with issues related to the abuse. When families are not able or not willing to acknowledge the abuse, individuals often have little option, for their own psychological health, but to distance themselves from family. Marianne, for example, spoke about the pain for her in confronting her family about the abuse, only to encounter complete denial, and her subsequent decision to distance herself from her family:

> If I ever talk to someone who is going through the issue, I will really try to help them to not make a confrontation unless they are really, really sure they can handle it, because it really sets you back for a long time. It put me down for a long time. You go through this real feeling of worthlessness; you just feel cheated....[My family's response was] total denial....When I confronted my father, he went so far as to say he was blameless, that he has never done anything wrong....My mother--she is living in a cloak of denial

> which my father has built around her and the rest of the family....She's says things like, "I don't want to believe that," and "I can't believe that." She didn't say, "I don't believe that," she says, "I don't want to believe it." It was a setback. It was a feeling of being rejected. It's like the ultimate rejection. All the time I felt--I would feel the loneliness and the neglect, but when it finally came, I really felt that my mother would believe me, and she would recognize that our family needs help...so many of my family have terrible emotional problems....I think what really set me back is the fact that this family I felt was going to come through, didn't come through. It was kind of like I had to grieve. Like a death. That's really how I felt--grieving the death of the family, and I couldn't go back to the way I was before and live in denial because I was dying. I just really was dying before....It took me quite a long time to really accept the rejection...and when I got over that and I started working--just working on building up myself...then, gradually, I started feeling better and the few people that were really supportive through everything really helped me, too, because I did have somebody that I could rely on....I'm a lot stronger [now] and...I know I feel strong because I didn't make a compromise with the family. They wanted me to forget it and pretend like nothing happened, and I wouldn't.

Marianne was not alone in making a decision to distance herself from her family of origin. As described previously, Fiona, too, made a decision to cut family ties because of her family's unwillingness to acknowledge the abuse. Diane talked about pulling away from her family because of their insistence that she "let it go" and stop "dwelling in the past."

Regardless of the reaction of family members, however, one of the important steps in healing is breaking the silence that surrounded one's abuse as a child. Doing so changes both the nature of the individual's relationship with the abuser and one's feelings about self, as Diane's comments clearly indicate:

> Part of what happens with a lot sexual abuse is that it's a secret, a pretty big secret, until you tell somebody....The first few times that I told somebody the things that had happened, it was really difficult. I felt so much shame. By giving voice to it, it's like saying I didn't deserve this, and I'm not going to keep it a secret anymore. With me and my father, there was a secret that we shared, and as long as we both kept quiet about it, we were tied by that secret. By telling somebody about it, I have been able to pull away from it. Even though he has been dead for almost six years, I have felt controlled still by him. By telling someone about the fact that he used to rape me from when I was a baby until I was eleven years old, I was able to step back and to feel less controlled by the situation. [I changed the rules] and, by me changing the rules, I'm taking back my own power that he took away from me.

Colleen, similarily, talked about the importance of breaking the silence and acting to counter a very strong injunction not to tell anyone about the abuse. For her, too, the act of doing so, while difficult, was important in regaining her "voice" and, with that, a sense of her own power:

> Once I got into the group and actually started talking to some other survivors, it was a real relief, but getting to that point...and facing it was very scary. So, while I did want to talk to people about it, it was always, always very difficult. It was a real challenge because there were so many voices inside me saying, "don't tell," because I had been punished for telling and I hadn't....It was [different than telling my therapist].

> It was more public...it was a little less safe....Once I had been through that group, then I could tell anybody, and there was a period when I did. But that was really important, that freeing up of my voice. That's really been a large part of the whole process for me --just being able to talk. It feels like that's really what was taken away from me the most was my voice.

That sense of regaining one's voice was also an important factor for Heather. For her, the healing process involved, in a very literal sense, beginning to put her experience in words and learning how to speak the truth of her experience to others:

> ...language plays a crucial part...if you can't articulate your experience...then you don't really have a voice....I think part of what I try to do in writing is to find a way to speak words, to sort of translate that experience into language. For a number of reasons...I don't have access to that language so there is a huge core of experience there that is inarticulable at the moment. Part of what I am trying to do is find ways of articulating it and putting it into words and speaking it and, I guess, owning it. Part of writing now is trying to find, [to] create the space to let that voice speak whatever it needs to speak and what I am discovering is that there is a number of voices. I think part of what I've gained [in therapy] is a place to go and practice speaking about this stuff. When I first started...seeing a counsellor...I really wasn't able to talk to her. It wasn't a matter of a personal "I just can't talk to her," but I couldn't speak, and I communicated by writing things down and she would read....I would bring this to her and she would read it and ask me basically yes or no questions which was about as much as I could cope with at the time. So, I think the process of therapy has been recovering actual physical voice and learning to speak

> and learning to be self-reflective and find a way to communicate the internal sort of realities to the outside world via language.

Finding the words to describe one's internal realities--one's feelings and needs--and learning to act on those feelings and needs is central in the process of making changes. Many of those changes occur in the context of one's relationships with others. Those changes, however, are rooted in a fundamental shift in one's relationship with self that begins with the development of the belief that one deserves to be cared about and not abused.

In the interpersonal sphere, that means taking steps to change or end abusive relationships. It also means changes in one's functioning, more generally, in the interpersonal sphere. It means, for example, learning, as Diane said in the interview, that "I can say no if I want, and it is OK. I can say yes if I want, and that is OK." In concrete terms, that means setting limits, or as Merry described it, not being "always available" to meet others' needs without regard for her own. It means, as Stephen said, learning "how to set up proper boundaries" and not "instantly...feel guilty" for saying no or responding with anger "if somebody kicks you in the teeth." It means, as Elizabeth said, learning about "assertiveness, communicating my feelings, risking." It means standing up for oneself. Diane, for example, talked about learning to defend herself when others try to define her in ways that are not congruent with her sense of self:

> One of the really big things for me was if somebody said something about me or to me about me that wasn't true....It was extremely difficult for me to stand up and say, "No, that's not right." It is still hard, but I am able to do it. I may not be able to do it immediately, but I do. I am able to eventually stand up and say, "No, that's not right."

It means not accepting the abusive behaviours of others, whether directed at self or not. For Colleen, that meant filing a complaint against a physician whose behaviours in examining her were clearly inappropriate and abusive. For George, that meant confronting a friend whose behaviours were abusive:

> ...he was hitting on all these 15 and 16 year old boys. I'm in the middle of saying, "Well, I was 18 when I had sex with my mom. This is just god-damn abuse." And I wasn't--I couldn't tolerate that.

On a personal level, changing one's relationship with self means learning to care for self. It means changing patterns of coping or getting one's needs met that are harmful to self. For Heather, for example, that meant learning to care for herself without slashing. For George, it meant beginning to allow himself to feel his emotions rather than avoiding them through compulsive or addictive behaviours. Although stopping behaviours that are harmful to self is important, simply stopping the particular behaviour is not sufficient. To make change, there is a need to understand the function the behaviour has served and to find other ways to deal with the need that the behaviour addresses. When that does not occur, the result is often simply a substitution of some other harmful behaviour. That was very clear in George's description of the range of compulsive behaviours in which he has engaged. While much of George's energy was directed toward controlling his alcoholism and compulsive sexual behaviours, he was also very much aware that compulsive spending, compulsive eating, and compulsive work were also ways of avoiding his feelings.

Learning to care for oneself in other ways means many things. In some cases, it means finding support from others in order to deal with difficult feelings as George was doing. In other cases, it means finding ways to care for oneself. Often, the particular ways in which individuals do that are very simple; however, the ability to soothe oneself is extremely important. The description of those behaviours by many of the participants in the study speaks to the significance of learning to take some simple steps to bring oneself pleasure and to soothe oneself. Diane, for example, described those kinds of behaviours as one of the important changes she has made in the process of healing:

> I do special things for myself. I burn incense. I was given, last Christmas, some potpourri. I like to burn some of that once in a while. I love the smell of it. I braid my hair. I do things with my hair. I give it a hot oil treatment once in a while. I--this may sound strange, but I put yogurt on it, let it sit for about an hour and then wash it out, and it comes out just like silk and really shiny. I do things to treat myself now, where I never did before.

For Marianne, learning to recognize "a bad day" as a sign that she needed to be gentle with herself rather than a sign that she had done something wrong was a major step:

> Patrice [therapist] really helped me to realize that everybody is entitled to a bad day. She says that feeling bad is just part of life; it's not that you have done something wrong. That has really helped me....When I get a bad day, then I think, "Oh yeah, this is my bad day." If it's a day that I can just stay at home and feel lousy and read or whatever, then I just make it my day at home....If I have previous plans, if they can be cancelled, I cancel them...and usually, when I take care of myself, I find that in a few hours, I start feeling better....I like to read and sometimes I just read...then I'll sleep or I'll do something that I like to do. Maybe I just feel like sewing or just something that is really unimportant, or I take a nice long bath and soak in the tub, but I find that just recognizing that I'm entitled

> to have a bad day is taking care of myself, and then it helps me to get over it.

Learning to care for oneself involves learning to be attentive to feelings and needs and using that information to guide one's actions. That same awareness is also a factor in beginning to make choices about the direction of one's life. Colleen, for example, talked about how the process of dealing with her abuse as a child led to a number of changes in her life:

> There have been so many different changes that I've made....Through this process, I decided to leave school...I had finished all my course work for my master's degree, and I was facing writing a thesis, but I was also realizing that I was doing something that I didn't really want to be doing and that I had been doing things all along in my life that other people thought were good for me--had recommended for me and had told me I was good at, but I had never taken any time to sit and think about what I wanted to do or who I was and meshed those things together.

For Colleen, the act of taking control of her own life also meant a decision to have her second child in an environment where she felt she had more control of the process than she had experienced during the birth of her first child and facing the pressures of others who opposed her decision:

> I really needed a lot of control. I needed to be able to set things up the way that I wanted, and I knew that if I went to the hospital that that control would be taken away and that I would just simply give up. I would hand over my body to the doctors, they would take the baby out, and I would go home. That wasn't what I wanted to go through--I really felt that I had a lot of healing from the first birth to do and so I did all sorts of things. I did all kinds of visualizations...and worked through a lot of things physically to set myself up for

> a home birth, took all the precautions I could, and enlisted all my friends and my mother and my daughter, and I had an absolutely wonderful, wonderful experience. It was just incredibly empowering...but it was a risk, and I had to face a lot of opposition to that and a lot of scare tactics...and I had to really reassure myself. I had to be very sure inside myself of what I was doing; that this was right for me.

That sense of taking control of one's life is very important in the context of an abusive past where one did not have control, did not have the power to change one's life. It is only through the process of making changes, taking the risk to do something differently that one begins to establish that sense of control. As that builds, one becomes more and more able to act to direct one's life in a direction of choice. In Colleen's case, for example, making a decision about her career path and taking control in the context of the birth of her second child allowed her to make yet another change:

> It was only after the birth that I was able to deal with the fact that I really didn't want the marriage to continue....I was in my relationship for ten years...and I had known all that time that I really didn't want to be there....I just didn't have the strength to leave, and I didn't know what I would do if I did. So it was through this process and really discovering the power that I had and my ability to actually control a lot of the things that happen in my life and to deal with the things that I can't that I was able to make changes for myself.

The sense of having some control over one's own life develops in the process of making changes. That process is an iterative one throughout the course of dealing with the abuse and healing from its effects. That is, changes are made, one's sense of control and confidence increases, the belief in one's ability to change and one's entitlement to decent treatment shifts, and more change becomes possible.

By experimenting and taking risks in various situations, individuals challenge old beliefs and explore new possibilities. As Diane said, in response to a question about how she learned to do something, "[by] trial and error, the same way you learn anything else." In part, change involves taking the risk to engage in the trial. It also involves the ability to see one's failures or "errors," not as signals to stop trying, but as indicators that more is to be learned. That reframing is important in acknowledging difficulty in making change and in focusing attention away from what did not occur to what can be learned from the experience.

The conception of change as a process of trial and learning from errors was clearly articulated by a number of participants in the study. In Elizabeth's words, the process is "try a bit, step back, try a bit further, a bit further, practice a bit, do a few things, and take it back so it will slowly build up." That process involves both refining one's skills and dealing with the fears that have prevented one from taking action in the past. Elizabeth, for example, talked about learning to be more assertive at work--becoming more skilled in her communication, taking progressively larger risks, dealing with negative responses, and so on. For her, acting "as if" she had the skill that she was working to achieve allowed her to begin the process of responding differently to the demands of others. At the same time, it worked to counter the beliefs that had previously stopped her from taking that kind of risk:

> I think [my beliefs also changed] through my actions. It's like act "as if" and then find out exactly that a shift--you know, act assertive and then start to feel assertive.

In addition to taking small steps to test beliefs about self and to build confidence, participants also actively sought support and models for change. Colleen, for example, talked about how her therapist's ability to set boundaries in the therapy relationship acted as a model for her in setting boundaries in other relationships. For many of the participants in the study, therapists acted as sources of support for them in making change. However, nearly all of the participants also talked about actively identifying other sources of support for themselves and reaching out to those people in times of need. In some cases, those people were other family members; in other cases, they were primarily friends. Many of the participants were involved in self-help groups of one kind or another. Individuals in those groups often served as supports, not only when painful memories surfaced or difficult issues arose, but also when risks were taken to make positive changes.

Participants in the study also talked about learning how to encourage and support their own actions. Sometimes affirmations were used for that purpose. Often, however, individuals simply learned to attend to their own inner voice and to use their voice in a supportive, rather than critical, manner. Helene, for example, was very clear in her description of that process:

> I would say [to myself] that "You don't have to feel like that 10 year old because you know this now. You know how to walk out; you know how to get out; you know you can get out. You know you have all of these skills, you have all of these smarts, and have all of this emotional wherewithal, and it's just really practice." It's like getting into a situation and saying, "OK, what do I have?" I used to sit there and mentally make a list and say, "OK, now I'm smart enough to handle this. OK, so we are all right." "Are you sure?" "Quite sure." "How smart?" "Smart enough." So I used to really--I mean, it's an experiential thing where you just get into situations where you say, "All right, you've done this one before, and you were fine. You really did it, and you came through, and you were fine. So it's very boring

> to do it again, but you can do it." I would make comparisons: "Well, last time you were in this shit for way longer. Look how well you've done to do it in ten days instead of two weeks." So, I used to just really work on [talking to myself].

Making changes may have many concrete results in an individual's life. Those changes may affect how one interacts with others and the choices that one makes regarding one's "work" in life, in the most general sense of that word. It is, however, on a meta-level that making changes is most important, because it is the *ability* to respond differently when current behaviours no longer meet one's needs or to take steps to change one's situation when the situation no longer meets one's needs that is central to psychological health. Making concrete changes results in increased self-confidence in one's ability to make changes and an increased sense of control over one's life. In the process, individuals develop a clearer sense of self and a clearer sense of the future holding a myriad possibilities from which one can choose to construct one's life.

Recovery Is...

Participants in the study clearly understood the process of recovery or healing as a process in the sense that it takes time and in the sense that the focus of the work changes over time. There were, however, a number of variations in the way in which the process was conceptualized by participants. Diane described the process, which she terms healing, as "a natural process" that she has come to understand with time. "I just have to take the first few steps, sometimes just the first step," she said, "and once the ball is rolling, then it keeps on going." In contrast, Elizabeth talked about change happening in a much more deliberate fashion, "step by agonizing step," particularly in the early stages of therapy, where the impetus to continue was primarily the desire to alleviate the level of pain that was being experienced. Heather described the process as one of slow, gradual change:

> I don't know how you finish this work, but, you know, when you're sort of done looking at things, they are just not here any more....There isn't a big, splashy recovery. I think, slowly, they just disappear--disappear implies magic --but they just get taken care of so they are not there any more.

Others marked the process more in terms of major turning points.

Participants also used different terms to describe the process. Some of the participants described the process as one of "healing" from the effects of their abuse. Others spoke of "recovery." For others, the process was one of learning to "deal with the abuse." In most cases, those differences depended on personal meanings attributed to those words and past experience in other contexts with particular terminology. For example, some of the participants who had a history of involvement with twelve-step groups such as Alcoholics Anonymous also used the term "recovery" with reference to the process of addressing the effects of their sexual abuse. Some participants without that involvement were uncomfortable with that term because of the same associations. Some participants used the terms interchangeably, making no distinctions. Others, however, such as Heather, saw important differences in the connotations of words used to conceptualize the process:

> I think, generally, I would use the word "recovery." I would be more comfortable using the word "recovery" as opposed to "healing." Quite often I sort of conceptualize it in a very political framework as well. Violence against women is something that's quite pervasive and a very public issue. Part of my way of thinking is that if women are not actively working out or trying to sort out the damage, we are reproducing the

> context that it occurs in. So I like the word "recovery" because it implies a cleaning up of a mess or working through some of the damage. Words like "healing" imply that it is a much more personal issue. I think of it as a much bigger issue that everybody...who [is] directly affected [has] to be responsible for--for cleaning it up. Otherwise, we just continue. It just reproduces itself over and over again. I try to look at it as political work as well as very personal and try to collapse the distinction between those two things...."Healing" [also] implies something of a much more spiritual realm, and I am far more of a materialist in that I locate things very politically and in a political context and within that language rather than from a spiritual place.

In Heather's case, the language used to describe the process was an important reflection of her understanding of abuse, its effects, and the importance of change in a broader social context. For others, as Heather suggests, there is a more spiritual dimension associated with the process, although that more typically develops during the process of healing rather than existing as a context in which the process begins. Diane, for example, talked about the development of a sense of faith that grew with her developing perspective of herself as a survivor. For her, appreciating the sense of inner strength that she must have had to survive and grow and face her past went hand in hand with a sense of some spiritual support. For others, a sense of spiritual presence in one's life seemed to be more related to a developing sense of connection with others. When one's ability to feel a connection with specific others grows, there is also a sense, in many cases, of more connection with the whole of humanity and a sense of being part of a larger whole which, for some, is clearly experienced in spiritual terms.

Despite those kinds of individual differences in understanding or perspective, there are many similarities in how participants view the process of recovery itself. All of the participants talked about periods of crisis, usually associated with the recovery of memories, that lessened over time as they faced the reality of their past and developed skills in handling the feelings associated with the abuse. As Elizabeth said, "I am more skilled, and I don't panic myself." In general, participants talked about learning to handle the memories and feelings that surfaced for them over time and developing the confidence that they would be able to handle whatever was surfacing. As a result, over time, periods of crisis become fewer and fewer.

Participants also talked about changes in the general level of intensity over the course of the healing process. As trust in the availability of support grew and as ability to face the reality of the abuse and tolerate the associated affect grew, the intensity of the memories generally increased for participants. In part, the intensity of the memories is associated with how central they are to core issues for the individual. Elizabeth, for example, described the process as increasing in intensity "but also going almost external to internal to the real core places...the most fragile and the most vulnerable places [that] are hidden the deepest." As those issues began to be resolved, that level of intensity began to decline and participants talked about becoming more and more focused on learning new skills and exploring new options in the present.

In general, however, participants in the study had no sense that there was an "end" to the process. As Diane said:

> It's not a disease that can be cured; it's not an illness to be cured. I will have this the rest of my life, and it will affect me the rest of my life--maybe not as much as what it is now, but I will always be nervous about being touched I think....There will always be things that are going to stay with me because it has such a huge impact on every part of me. I don't think that there is

> any part of me that it didn't touch....[I]t's pretty hard to have something like that happen and not have something in the present trigger feelings....I don't know that that's something that will ever go away completely.

What does change, however, is the ability to deal differently with those kinds of situations, as Helene suggests in the following excerpt:

> When you haven't separated out from the abuse, anything that happens to you then gets tied into the abuse...that's what you key into...if you are feeling strongly about [something]...what you pull forward are those feelings....I'm not saying that you ever get over that. I'm saying that you can be separated out from it and have--you can have your own stuff.

What that implies is a very different relationship with the abuse. For Colleen, that means no longer seeking to avoid the memories from the past but welcoming them as sources of information that allow her to better understand herself in the present:

> I...need that knowledge. I...need to know what happened back then....It's not like I go back there and get stuck there. It's that I deal with that knowledge and incorporate it and look at what that means to me and what that has meant to me, and, very often, there are connections to whatever is happening in my life at the time, and I can learn from it. It gives me a better basis to evaluate things.

That sense of reclaiming oneself is present, also, in Heather's comments about developing a relationship with the part of herself that became dissociated in order for her to continue to function in the environment in which she existed as a child:

> When children dissociate, I think the part that dissociates is still...very much alive and present but is sort of repressed and not available....I think, in some

> ways, it's a process of making it safe for some sort of return. I don't think that the return implies a recovery to the degree--to the place of the pre-abusive self. I mean, I don't really think that you can go back and recover that dissociated part, but I do think, though, that there is experience and there's language and there's a voice...that belong to the dissociated part that has to be integrated into things....I don't have any sense of...complete integration, and I don't think I believe that that's really possible. I think, in some ways, that the part that is dissociated will always remain dissociated, but I think there are any number of really healthy ways to build a relationship there...with the feelings and with the part that's dissociated....They are separate in one sense, but there is a point of integration when I have them--have the feelings. They become mine in that sense, but it very much is negotiation with something that's separate.

Elizabeth, in contrast, anticipated a time when the abuse was "fully integrated":

> I do believe there is going to be a very big shift...getting into a more integrated life where...I can just be and live and do....I think there won't be any new stuff...just kind of a gradual evening out of my life, where the incest and sexual abuse...has been fully integrated with the new person I am and all my skills and it's just part of who I am...I did a picture a while ago...I guess I was trying to do a healing picture or something for future--but it was being in this house and everything was really lovely and green...and I had an easel with a picture and, on the picture, was something as simple as "my past abuse"...I will never forget it. It will always be a part, but it's not [all of the picture].

Both Heather and Elizabeth, however, clearly saw recovery as involving access to one's past and "ownership" of one's experience as a child. What is central in their descriptions is that one comes to a point where the abuse that occurred in childhood and its emotional impact can be acknowledged as part of one's past. It is also clear that participants see that acknowledgement as being important in putting the abuse in perspective; that is, it is part of what has influenced one's development, but it is not all of one's past, nor does it need to be all of one's present or future. In Colleen's words:

> [The abuse is] more in the past--it's not so much that it's in the past, but that I'm in the present--in the future, too. I now have of view of myself here where I am now and also where I want to be going, whereas, before, it was very much [that] I was carrying the past with me and trying to work through it. I've now sort of put it back there.

The sense of reclaiming oneself that many of the participants in the study described is part of a general change in the relationship of the individual with him or her self. There are a number of facets to the change in relationship with self. One is an increased level of self-awareness and a much stronger sense of self. In Stephen's words, "I have been working hard on...just being who I am instead of what the situation wants me to be." That means being aware of one's feelings and needs and acting on that awareness. The result, as Marianne describes, is a real sense of self and a sense of entitlement to one's own life:

> I feel more alive. I feel more human than I ever felt in my life before. I never felt that I was my own person before....For the first time in my life, I realize that I am entitled to my life, and I don't have to live my life for everybody.

Diane's comments, interestingly, are almost a virtual echo of that:

> I am a lot stronger now than I what I was five years ago, two years ago even. I feel stronger inside...a little more of a whole person....I know now that I deserved to have my own life. I deserve to be independent. I deserve some happiness. Most of all I just deserve to just be me and to have me for myself. I don't have to do what somebody else wants me to do if I don't want to....I know now that I have rights.

Participants also reported changes in their understanding of self and, together with that, changes in their feelings toward themselves. One of the most significant changes is an end to the feelings of shame associated with the abuse. Elizabeth, for example, talked about that as one of the changes that occurred for her in the course of therapy:

> And then there's the feelings around...how do I feel as a survivor? For a long time, it was incredible shame...just embarrassed, and now I don't feel shame about it at all.

For Marianne, understanding that she was not responsible for the abuse led to a sense of peace with herself and an ability to accept herself in a way that she had never been able to do so before:

> I have a lot of peace now...I don't feel so guilty...this guilt of what a terrible person I am...burdens I carried a lot that I never knew I was carrying, and I notice that it's changed me in a lot of ways. I am more patient. People used to tell me I was patient with my children. Maybe I was on the outside. On the inside, I was ready to strangle them...I tried to exercise some self control with the children, but I never felt relaxed inside. Now I feel relaxed on the inside. I have that inner peace now and that pain is gone, that pain I carried all those years....Now that I don't have to carry that pain and that guilt all the time, I can feel peaceful and I can feel good about myself. Even now, when I do something

> that is ridiculous or stupid, I can accept that I am just an imperfect human, whereas, before, I could never accept the fact that I could make mistakes. If I did, I would carry the guilt...to ridiculous lengths of self destruction almost. I really feel it is just understanding myself.

For Diane, losing the sense of shame about the abuse meant changes, not only in how she viewed herself, but in how she presented herself to the world:

> I walk with my shoulders up straighter than I used to....I am more comfortable making eye contact with people. I was so guilt-ridden and so full of shame that making eye contact with somebody was really intimidating. It was almost impossible at one time....The more I heal, the more comfortable I am with it.

Merry's assessment was that one of the most important things to come out of her therapy was "the sense of comfort with myself...just more self-acceptance." That self-acceptance can show itself in many ways. It may show itself in terms of comfort with one's physical self, as it did for Marianne:

> I feel better about my body....For the first time, I can wear things tucked in, and I have gained weight. I am heavier now than I have ever been in my life, and yet now I can wear shirts tucked in and still feel really good about myself. I don't feel that everybody is looking at my ugly body, because I don't feel ugly any more.

It may show in terms of one's willingness to look at aspects of self that may not be flattering, as was the case for Fiona:

> I've got more self honesty....If you are honest, then you can look at things...looking at...some realities about myself...maybe some of the not so good things about me...I can look at and say, "OK, it's not so good," rather than being so frightened of it that I have to deny all the time.

It may show itself in one's behaviours, as Fiona also indicated:

> I laugh a lot more, I smile a lot more. I think part of it is getting in touch with the little kid and really just letting myself just totally enjoy being a brat and being mischievous.

It may show itself in one's relations with others or in one's feelings toward self, as it did for Diane:

> [It] makes a difference in how I relate to people, how friendly I am. People that have known me for quite a few years tell me that my face is softer now than what it used to be. People find it easier to approach me. I make friends easier. I am not as defensive to other people....It's also in the level of what I give to myself. I'm starting to feel like I deserve to have some of my needs met....I'm starting to care about myself....It's been a very long time since I've felt very much self hate. I may not like myself very much sometimes, but it's been a long time since I've felt the intense self hate that...I lived with most of my life.

For Stephen, too, the changes showed in his relationships with others and, more generally, in living his life in a manner less governed by fear:

> I've changed a lot in the past year and a half. My patience--people that I work with have told me that....I smile a lot now. I walk up to people. When I was in Jamaica was a prime example. I walked up to people that were complete and utter strangers and would open discussion. I wouldn't sit in the corner and just wallow. I wasn't scared of myself anymore or what people would think of me. Why would they talk to me?...I actually go to the dentist now. I said that to [my friend], and she laughed and laughed and laughed. I said, "Guess what? I've been to the dentist three times in the past week." I didn't like anybody poking and

> prodding around in my mouth, and when I was a kid I was to a dentist, and he just sort of ripped a couple of teeth out--"well, kids don't feel pain." Somewhere in one of the books that I've read that it's quite prevalent in a lot of people who were sexually abused as children--a fear of dentists--it's an invasion of the body. Until I read it, I'd never really correlated the two, but when you think about it, it makes sense.

The increased feelings of self-acceptance and comfort with self that participants talked about is related to a fundamental shift in beliefs about self, particularly, about one's worth as a person and one's lack of culpability for the abuse. One of the other changes in beliefs about self that participants described as occurring in the process of healing is the belief that one has the power to make a difference in one's own life. In Elizabeth's words:

> I am starting to feel good about myself and starting to believe in myself and being able to feel like I have some power--actually being able to go and say something to someone that would change my world in way that is positive.

The effect of that shift is to foster a sense of hope in the future and to shift attention away from the past to the future. As Diane said in the interview, "I feel [now] like maybe I have a future. I am actually starting to think about the future." That shift of attention to the future was something that virtually all of the participants addressed in some fashion, whether it was in terms of one's work in the future or relationships or both. The ability to see oneself as having some power to effect changes in one's own life, like the ability to see oneself as a person of value, is central to one's relationship with self.

Changes in one's relationship with self are not the only changes that participants reported in the course of healing. Changes in one's relationships with others were also reported as important. In many cases, those changes were related to changes in the relationship with self. For example, Heather talked about learning to open herself to other relationships. However, that shift was related to increased confidence in her ability to look after herself in various situations. Developing an ability to set limits in relationships and to express one's feelings and needs in relationships is also related to changes in the relationship with self, specifically, increased self-awareness and an increased sense that one is entitled to have needs and to set limits. Learning to trust others is related to developing self awareness and trust in self. In Diane's words:

> I've gone from believing that nobody can be trusted to being able to be more selective. I pay more attention to what I am feeling, how I am reacting to things, [and] I trust myself more.

Valuing reciprocity in relationships is related to believing that one deserves not only to give, but to receive, in relationships and developing the confidence in one's choices and in one's ability to care for self that allows one to be vulnerable in relationships. Ending abusive relationships or unsatisfactory relationships or simply making a decision to spend time with people who are accepting, rather than people who are continually critical, is related to increased self-acceptance and a sense that one deserves to be cared for as one is in relationships. For Fiona, that made a difference in her choice of friends:

> There is a part of me that has gotten to the point where I just say, "there is something about me that some people may not like, but I do," and so I will hang out with people who like that, too. I'm tired of feeling like I have to be a particular way, so I hang around with other people who are [accepting of me].

Participants also talked about understanding the ways in which the abuse they experienced in childhood has affected their relationships as adults and learning to "separate" past and present in those relationships. That, too, is related to increased self-awareness and a level of self-acceptance that makes it possible to look at one's own behaviours, positive or negative.

Recovery can also be viewed in terms of the cessation of "symptoms" that prompted individuals to seek help in dealing with the abuse they experienced in childhood. In some cases, participants noted those changes as being important. Stephen, for example, talked about a decline in the number of flashbacks that he experienced. Marianne talked about having fewer nightmares and no longer experiencing many of the symptoms of depression that had been prevalent since she was a child. George talked about beginning to maintain abstinence with respect to sexually compulsive behaviours. In many of the cases, however, participants did not focus on those changes even when it was clear that recovery had involved those changes. From the point of view of the participants, what appeared to be most central were the changes in the relationship with self.

A majority of the participants in the study were in a therapy relationship at the time of the interview, although some were contemplating and planning termination and most had a sense of the issues remaining for them prior to seeking termination. The following indicators for termination are based on partipants' views about what recovery means and comments about termination of therapy:

1. The client does not feel that there is anything significant left to address with respect to the abuse and that significant changes in one's life have been made. In two cases, participants talked about having a sense of memories still repressed and an associated sense of fear. Both individuals saw the need to continue in therapy until those memories were uncovered. That does not mean that all of one's memories need to have been processed in therapy. It means,

rather, that the client feels that she or he can handle memories that may surface, without the help of the therapist, i.e., she or he does not feel extreme fear at the prospect of dealing with whatever may surface and has developed and learned to use other sources of support.

2. The client has a reasonable level of self-awareness, i.e., has the ability to identify her or his feelings and needs, is able to make connections between the past and present, and is able to make a conscious choice to respond differently.

3. The "gradual evening out" of one's life that Elizabeth noted is evident, i.e., memories of the abuse no longer evoke ongoing crisis states, and there is a shift in focus from the past to the present and to the future.

4. The client has gone as far as she or he can or is willing to go for the time being. For example, the individual may not be willing to risk entering an intimate relationship and has no desire to take that step in the immediate future.

In anticipating the ending of a therapy relationship, two reactions were expressed that suggest termination issues that need to be addressed. One was the expectation of a sense of disorientation. In Heather's words:

> I imagine probably a long period of complete disorientation. You know the sense of when you finish writing your final exams and there's a period of a day where you feel like you should always be studying, but you have nothing to study any more, but you are not quite ready to start something else.

The other issue is that of loss. Colleen, for example, talked about finding herself going through a period of mourning. Elizabeth, too, talked about anticipating a sense of loss:

> I don't know what it is going to be like to leave because I have been in a long time so it is going to be a process. In a sense, I think I even have some denial about what kind of process, because, on one hand, I

> think, intellectually, this is how it should be so this how it will be, but, on the other hand, it's like I've got this incredible attachment, and I do, actually, when I think about it now, because here's one person who's always been there, and I always know she's been there, so it will be a loss, and I guess I don't know what kind of relationship we will have after.

In both cases those are issues that are obviously addressed by talking about what the termination means and about what is possible in the future, by "phasing out" therapy rather than terminating abruptly, and so on. For Merry, her therapist's suggestion that she think about a ritual to mark that transition was one that led her to review what had been important for her in her healing and to create a symbol of her healing that would be a lasting reminder of what was important for her in that process. The following is her description of her plans for that ritual and her description of what recovery has meant for her:

> Fern and I have talked about ritual a lot, as a passage, as marking of a passage....Fern had just asked me to think about a ritual because we are probably coming to closure...and it just suddenly dawned on me that I want to create a flower garden in my back yard--just a flower garden--MY flower garden....I am going to get one of those fire pits, and I've designed the garden and dirt comes this week-end....I am going to create the garden, and then I am going to have the most important people involved in this process to some sort of function in the garden. I think that it's a symbol, and the ritual is in the creation of it. I actually wept when I told Fern about it, because for me to be able to take the time to do that is marvellous....I think the flower image for me is a strong one and that comes from my childhood. Flowers were a very positive thing in my childhood. California poppies are one of my most vivid memories. A

friend of my mom's was a very positive influence on my life...she always had a garden, and I was always over in it. My mom had a flower garden. Then, the image of growth and beauty and also the sensuality of flowers and the colours that [are]...in the design--the purples and blues. I did a painting, in water colours, and was totally amazed that this painting came out intense--deep purple, red, green--and red was the colour I had the least of so I thought I would be rational enough to conserve it. So the garden is now coming out in my mind in purples and blues and reds and oranges--very intense colours....The California poppies I hope I can find, and, as a little girl, I used to plant zinnias, so I will have those. My mom always had marigolds. I want to get evening stalks because they have the wonderful scent, and I love scent....I would like to get those in a pale, pale pink because that's [my partner's] favourite colour, and then I will have ferns throughout it. It's going to be a picture of the process in some ways and just, I hope, just ragingly beautiful....I said [a picture of the process] because there is an image that comes to me often--it's like a white light, and I think it comes from the fact that Fern--I was driving to Winnipeg that year and...I said I was really afraid to do that. I had never driven across the prairies by myself. It turned out to be the most wonderful experience. But Fern had said to me, "Just surround yourself with white light"...so, as I was leaving Winnipeg...and I stopped to get gas and the guy was really busy but I had him check my oil, and I drove away from the gas station, and I was heading out onto the highway, and I just remembered what Fern had said, so I thought, "I will put this white light around me," and I noticed that the hood of the car wasn't firmly latched--it wasn't latched at all--so I pulled over and put it down, so that is a significant thing for me...so

> I am planning on having some sort of swath of white through it.... When I first went to therapy back in the late '70's or early '80's, the therapist that I went to then--I always wore black slacks or...a plain outfit...and she said to me once, "I really like your socks." I would buy the wildest socks, and it was like I was keeping this personality way down there, hidden underneath, but I still knew they were there. So I think that's sort of it--the garden's coming out in intense colours, like the painting I did--and valuing that. Do I have to be that all-giving, ever-sensitive--you know how people like to perceive what women are--the only way they like to perceive women--soft. And I am learning that I am strong and capable and all of those things. I think [the symbols] are important partly because I am a visual person so I will be able to see something that I have created, from within myself....One of my favourite people is Vita Sackville West and she ended up going on and having this wonderful garden...and actually writing articles for the London Times on gardening. I think it--the actual gardening thing to me has--the tactile thing--I love the smell of the earth, I love touching the earth--and I've not ever given myself that. There is also a tie to my mother there. She always had a huge garden and, in a very negative way, always forced me to work in it, so it's almost like I want to reclaim something, and the flower, to me--lately, that's what I have been feeling like. I have been feeling like this blossom...just being is enough, just being who I am is enough, and that is somewhat like being a flower. I mean...who has to explain anything if you are looking at a flower.

Merry's garden is a symbolic representation of what the process of recovery meant for her. Within that description, however, are the same themes iterated by all the participants.

Recovery involves taking time for oneself. It involves creation. It draws from the past and transforms the past. It involves risks taken and the reassurance of others. It involves the expression of intense feeling, recognition of one's own preferences and needs, and a sense of connection with others and the physical world. Most of all, it involves the acceptance of self and the realization that "just being who I am is enough."

Chapter V
Discussion

The purpose of this chapter is to further explore the relationships between the various elements of the process of recovery described in Chapter IV and, in the context of other literature on human change processes, to develop hypotheses about the nature of the change process.

The process of recovering from childhood sexual abuse is described in Chapter IV as beginning with the decision to seek help and the establishment of a therapeutic relationship or a sense of connection with others who provide a safe environment in which healing and recovery can occur. Within that environment, the individual begins to build internal resources, strengthening the self.

The sense of being in a supportive environment and having internal resources to deal with pain allows the individual to begin to explore the past. That process involves accessing childhood experiences that have typically been dissociated in part, or in whole, and processing those memories in the context of the present, that is, as an adult with resources that did not exist in childhood.

Accessing that experience in a context different from that which existed in the individual's childhood provides an opportunity for the experience to acquire different meaning and for new possibilities in one's relationship to self and others to be generated. The generation of new possibilities opens the door for changes in how one's life is lived in the present.

As changes are made, the individual ceases to be "the creature of the abuse"; one's actions are no longer controlled or limited by the abuse in one's past. That freedom to explore who one might be, in the present, and in the future, is the essence of recovery.

A number of writers have conceptualized the process of recovery as proceeding through stages. Herman (1992b), for example, describes three stages which she labels "safety," "remembrance and mourning," and "reconnection" and compares them with similar conceptions of recovery from both specific and general types of post-traumatic stress disorders. All of those models describe the process of recovery from trauma as beginning with the stabilization of symptoms in the present and the development of a safe environment, followed by a period of exploration of traumatic memories, and ending with the development of new ways of being in the present.

The process described by the participants in this study follows a similar pattern. The elements described as "making connection" and "building internal resources" clearly relate to the establishment of safety. "Reconnecting dissociated experience" and "understanding differently" involve the exploration and integration of memories and the resolution of issues related to the abuse. "Making changes" involves dealing with the effects of being abused as a child on one's functioning in the present, learning new skills, exploring new possibilities, and "recreating the self" in the present.

However, the process described by participants in this study is considerably less straight-forward, and the elements more interconnected, than others have suggested. Figure 1 below depicts the elements of the process of recovery and the relationships between those elements.

FIGURE 1

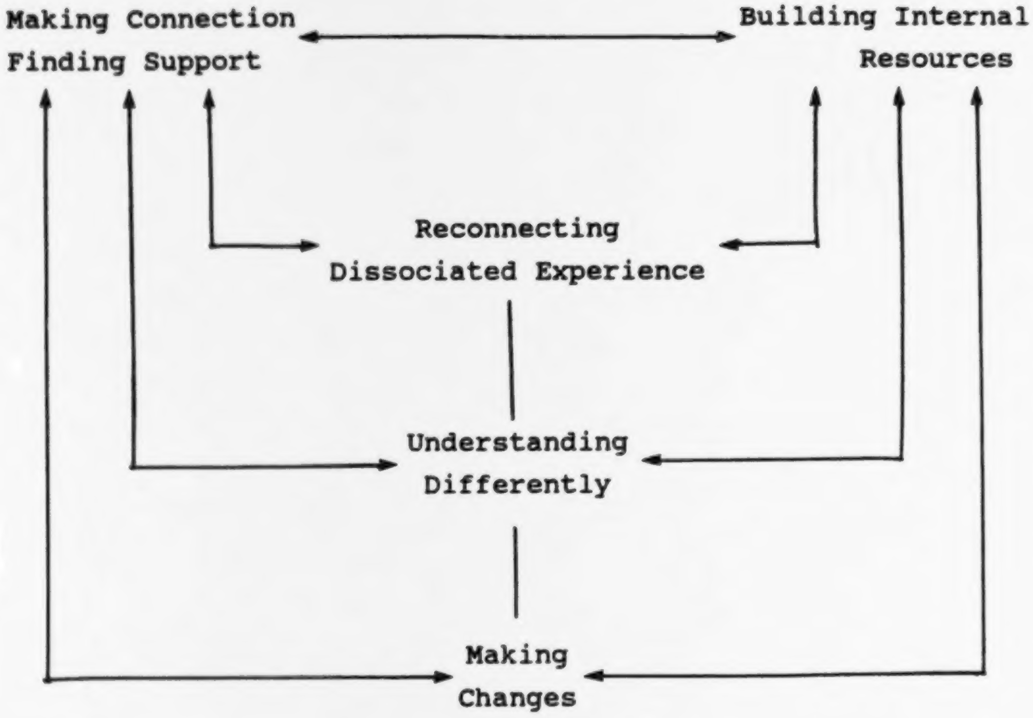

Making Connection
Finding Support
Building Internal
Resources
Reconnecting
Dissociated Experience
Understanding
Differently
Making
Changes

Figure 1. Elements in the process of recovery

The process, rather than being linear in nature, is perhaps better described as recursive. All of the processes described occur throughout the healing process. Making connection (in the context of a therapy relationship, developing a therapeutic relationship) is particularly important in the early stages of the process. However, it is a gradual process that occurs over time and is a function of the interaction that occurs in the relationship as the individual develops internal resources, reconnects dissociated experience, and makes changes in the present. Similarily, making changes in the present is a gradual process that occurs over the course of the healing process and, in many ways, facilitates the development of internal resources, connection with others, and understanding differently as much as it depends on those processes.

One of the specific changes often cited by participants, namely, beginning to take steps to nurture or protect self, is an excellent example of the interaction between various elements of the recovery process. In some cases, taking steps to nurture self contributed to a stronger sense of self, specifically, to a sense of being able to look after oneself in a variety of situations. In some cases, taking steps to nurture self led to a shift in the perception of the extent to which one deserved to be cared for. In other cases, those processes occurred in the reverse order. Participants sometimes needed to learn skills and develop confidence before they were able to take steps to look after themselves in different ways, and, sometimes, participants needed to see themselves differently before they were able to take steps to nurture or protect self.

It is important, then, to recognize that the process of recovery is not straight-forward and not prescriptive. In terms of the specific events that occur in the process of recovery or their timing, there may be considerable individual variation. Each individual's history is unique. The particular dynamics associated with the abuse and the particular context in which the abuse occurred are different for every individual. In addition, individuals themselves differ in terms of variables, such as temperament or intelligence, that may affect how they respond to the abuse.

For therapists to be helpful in facilitating recovery, it is important that they understand the dynamics associated with the abuse, the context in which it occurred, and how the individual responded to the abuse, specifically, how the individual understood what was happening and how she or he coped. That kind of understanding is important in ensuring that the therapy relationship does not, in more or less subtle ways, replicate the abuse experience. Furthermore, the process of gaining that understanding conveys to the individual that his or her experience is important, that it is valid, and that it can be shared. In other words, the process itself counters previous experience conveying the message that the individual's experience is not important, or not valid, or not able to be shared.

As has been suggested elsewhere, not replicating the abuse experience is important in establishing a sense of safety so that the individual can continue the work of healing. It is also important in terms of creating a new possibility for the individual, namely, that it is possible to have a close relationship with another person that is not only nonabusive but accepting and supportive. As Herman (1992b) says:

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation. (p. 133)

There are two ideas of central importance in the preceding quotation. The first is that recovery involves experiences that are fundamentally different from those of the individual's childhood. The second is that those experiences involve the individual's relationships with others. Child sexual abuse always involves another. It is, by definition, the sexual use of a child to meet the needs of the other without regard for the consequences to the child. Such experiences affect the beliefs, assumptions, and expectations that children develop about others. In addition, because children's understanding of self is developed in the context of relationships with others, such experiences affect the way in which the self is construed.

As Guidano (1987) and others have suggested, self knowledge develops through an individual's interaction with the environment. In Guidano's words:

> ...early experiences work as "criterion images," which essentially *regulate*, but do not totally determine, the subsequent making and matching processes through which the individual actively constructs knowledge of the self and the world. (p. 40)

Similarily Bowlby (1982) suggests that individuals develop working models of relationships, based on their early experience with the primary attachment figure, that guide their behaviour in subsequent relationships and form the basis of the personality.

On the basis of that experience, individuals develop expectations about others (e.g., the extent to which others are trustworthy, accessible, caring, and responsive vs. untrustworthy, inaccessible, uncaring, and unresponsive) and assumptions about self (e.g., worthy and capable of getting others' attention vs. unworthy and incapable of getting needed attention).

It is important to recognize that it is the *interaction* with others that forms the basis for an individual's understanding of self and the world. The individual is not a passive body in that process, but is, rather, an active participant seeking, in a variety of ways, to meet his or her goals in that particular context. For a young child, Bowlby argues that the goal is to establish an attachment bond, that is, to maintain proximity with some particular individual for the purposes of survival. The particular behaviour in which a child engages to meet that goal depends upon the specific nature of his or her interpersonal environment.

In one of the earliest articles to recognize that children's reactions to living in an abusive environment could be understood as positive attempts to cope, Summit (1983) argued:

> For the child within a dependent relationship sexual molestation is not typically a one-time occurrence....If the child did not seek or did not receive immediate protective intervention, there is no further option to stop the abuse. The only healthy option left for the child is to learn to accept the situation and to survive....The healthy, normal, emotionally resilient child will learn to accommodate to the reality of continuing sexual abuse. There is the challenge of accommodating not only to escalating sexual demands but to an increasing consciousness of betrayal and objectification by someone who is ordinarily idealized as a protective, altruistic, loving parental figure. (p. 184)

Summit further argued that the nature of that accommodation often involves the adoption of an understanding of self that allows the child to maintain hope in her or his ability to meet basic needs:

> The child faced with continuing helpless victimization must learn to somehow achieve a sense of power and control. The child cannot safely conceptualize that a parent might be ruthless and self-serving; such a conclusion is tantamount to abandonment and annihilation. The only acceptable alternative for the child is to believe that she has provoked the painful encounters and to hope that by learning to be good she can earn love and acceptance. The desperate assumption of responsibility and the inevitable failure to earn relief set the foundation for self-hate and what Shengold describes as a vertical split in reality testing.(p. 184)

As Summit goes on to suggest, "being good" may come to mean being available without complaint to parent's sexual demands, keeping the abuse secret in order to protect siblings from sexual involvement, to protect mother from disintegration, to protect father from temptation, to preserve the security of the home, or any number of other consequences directly or indirectly suggested to the child or inferred by the child.

Summit's purpose in writing the article was to explain some of the behaviours that abused children display that are not always understandable to individuals in the larger social system who have contact with those children following a disclosure of sexual abuse. It is clear, however, that the "accommodation" that children make to their environment often has lasting effects; that is, simply changing the environment does not necessarily change ways of interacting with others or views of self that have developed in that environment.

Within a constructivist frame of reference, that process of accommodation results in particular "patterns of knowing" that influence the individual's current experience. In Mahoney and Lyddon's (1988) words:

> Through the process of exploring and adapting to the environment, individuals impose abstractions (deep structural rules) upon the particulars of their experience and actively construe representational models of themselves and their world." (p. 211)

Mahoney (1991) suggests, as do Guidano and others, that those patterns or "structural rules" involve "predominantly tacit (beyond awareness) processes that constrain (but do not specify) the contents of conscious experience" (p. 104). The mind is further characterized as proactive as well as reactive in nature, utilizing "feed-forward" processes as well as feed-back processes in order to guide behaviour in the current environment. In other words, those patterns structure the individual's expectations and, consequently, what is attended to in the environment and how information is interpreted.

Bretherton (1985), in describing that process in terms of attachment theory, says:

> The relative safety or danger of a situation and an attachment figure's availability and responsiveness are, according to Bowlby,...not appraised completely afresh

> every time. Through continual transactions with the world of persons and objects, the child constructs increasingly complex internal working models of that world and of the significant persons in it, including the self....These models are useful in appraising and guiding behavior in new situations....Internal working models of attachment figures and self, once organized, tend to operate outside conscious awareness. For this reason, and because new information is assimilated to existing models, the models tend to be resistant to dramatic change. (pp. 11-12)

Bowlby (1980) argues that representational models tend to be outside awareness because "both the cognitive and action components of attachment...become so engrained (in technical terms overlearned) that they come to operate automatically" (p. 55) in the same way that many physical skills become automatic.

The need for human beings, as living systems, to maintain a sense of internal coherence and integrity further strengthens the tendency for representational models to maintain consistency. In Mahoney and Lyddon's (1988) words:

> ...living systems continually organize and reorganize themselves so as to maintain the integrity of their structure. Through an ongoing process of self-renewal, perturbations arising from interactions with the world are assimilated into more complex and integrated levels of self-identity. Within this perspective, the mind is viewed as an *autonomous* system concerned with its own self-maintenance and self-renewal." (p. 209)

Similarily, Ford and Ford (1987) argue that "living systems function to establish and maintain patterns of steady state organization in the face of variable, instability-producing influences of both internal and external origin" (p. 40). In other words, patterns of organizing one's experience (representational models) serve to provide human beings with the means to make order, or meaning, in order to function effectively in the world. If human beings did not have that capability, the world would be entirely unpredictable, there would be no basis for guiding one's actions, and the survival of the species would arguably be imperiled.

Even when the particular representational models of self and the world that any given individual develops appear to be maladaptive, the process itself is one that has adaptive value for the species. It is understandable, therefore, that one's formative representations, that is, the first basic representations upon which later elaboration takes place, are not replaceable. That is not to say that change is not possible. Clearly, one's experience throughout life continues to affect how one sees self and others. However, the organism's need to maintain a sense of coherence and integrity means that, in the normal course of events, new experiences are likely to be interpreted in light of one's past experience. Furthermore, experiences that are not assimilable within the frames of reference that have been constructed may simply be discounted or excluded from awareness. For those reasons, change is not a simple process.

It is important to recognize that representational models are constructed within a particular context. That is, representational models are developed at a time of dependency and at a time when children's cognitive capacities are not fully developed. Those factors constrain the range of constructive possibilities. Bowlby (1980), in addressing the issue of the child's dependent state, argues that children will exclude the following types of information in the construction of their representational models because of their need to maintain attachment:

> (a) information that leads...attachment behaviour and feeling to be aroused intensely but to remain unassuaged, and perhaps even to be punished, and (b) information that [they] know [their] parent(s) do not wish [them] to know

> about and would punish [them] for accepting as true." (p. 73)

While the concept of defensive exclusion has some explanatory power, it is important to distinguish between the exclusion of information from awareness and the exclusion of information in the construction of representational models. In practice, individuals act in the world on the basis of their experience regardless of whether or not that experience is within conscious awareness. In other words, information may be included in the construction of representational models despite being outside conscious awareness.

Furthermore, that information, or knowledge, may exist in various forms. Braun (1988a, 1988b), in offering an explanation for amnesia for childhood abuse, argues that memory has four components which he labels behaviour, affect, sensation, and knowledge (cognitive awareness). What he is suggesting, in effect, is that knowledge has various forms or various components: a cognitive component, an affective component, and a physical or physiological component comprised of both voluntary and involuntary reaction patterns.

In the normal course of events, our knowledge is a composite of all those components. Braun suggests, however, that, in the face of experience that is too overwhelming to acknowledge, individuals will separate the various aspects of the experience, or fragment it, in order to handle it. In other words, dissociation will occur. In Braun's model, all the elements of experience may be dissociated or the dissociation may exist between only some of the elements of experience.

Herman (1992b) argues that abused children are particularly prone to use dissociation or fragmentation as a means of coping because living in an abusive environment interferes with the development of self-soothing skills:

> In the course of normal development, a child achieves a secure sense of autonomy by forming inner representations

> of trustworthy and dependable caretakers, representations that can be evoked mentally in moments of distress....In a climate of chronic childhood abuse, these inner representations cannot form in the first place; they are repeatedly, violently, shattered by traumatic experience....Thus, under conditions of chronic childhood abuse, fragmentation becomes the central principle of personality organization. Fragmentation in consciousness prevents the ordinary integration of knowledge, memory, emotional states, and bodily experience.... (p. 107)

Dissociation or fragmentation has a number of consequences. The first is that it increases the likelihood of spurious connections as individuals attempt to understand their responses in situations where particular representations or schema are activated. For example, individuals may interpret their reactions as indications of mental instability, they may misinterpret the motivations of others such that their responses are understandable, and so on. The second is that the dissociated knowledge is not readily available for use in reappraising one's representational models as the individual's environment, or interpersonal context, changes.

Optimally, one's representational models are continually revised in the light of new information. There is a state of dynamic equilibrium between the assimilation of new information to existing structures and the accommodation of those structures that allows the organism to maintain stability while adapting to changes in the environment. There is some evidence that the cognitive structures of abused children are more rigid/less flexible than the cognitive structures of children without a history of abuse. In other words, the balance between assimilation and accommodation is weighted in favour of assimilation.

In investigating children's cognitions in three domains, scientific inferential thinking, knowledge of self, and understanding of others, Fish-Murray, C.C., Koby, E.V., and van der Kolk, B.A. (1987) found that:

> The abused children...found it hard to shift sets, not only with physical objects but with self/other categories. Reciprocal role playing was especially hard for them. They found it difficult to use flexible, mobile imagery to work out problems, to anticipate solutions, and to visualize what alternatives would look like. They found it particularly hard to encounter the uncertainty and unpredictability of some of the tests." (p. 100)

Fish-Murray et al. concluded that the abused children in the study showed inflexibility in organized schemas and structures in all domains. If "the key to multiple paths of cognitive organization is flexibility and variability" as the authors, citing Piaget, argue, lack of flexibility makes it difficult to entertain new possibilities. In other words, there is less likelihood for representational models or cognitive structures to be modified in the face of new information.

There are a number of explanations for why the cognitive structures of abused children might be more rigid. Fish-Murray et al. suggest that the intrusion of visual images of abuse in response to emotional triggers keeps the child "pulled toward predominantly visual and less developed and interactive structures of thought....[and] centered on his own world and preoperational in logic" (p. 99). Others have focused on what Chemtob, Roitblat, Hamada, Carlson, and Twentyman (1988) call a "survival mode" of functioning which, involves a narrow focusing of attention and concentration on potential signs of danger, as well as increased physiological arousal and increased psychological arousal (sensitivity) which prepares the individual to deal with impending danger.

Herman (1992a, 1992b) talks about the effects of living in an environment marked by chronic abuse in similar terms. She argues that, in a chronically abusive environment, the configuration of symptoms typically seen in victims of single-incident trauma shift such that avoidance and constriction become predominant:

> ...the features of post-traumatic stress disorder that become most exaggerated in chronically traumatized people are avoidance or constriction. When the victim has been reduced to a goal of simple survival, psychological constriction becomes an essential form of adaptation. This narrowing applies to every aspect of life--to relationships, activities, thoughts, memories, emotions, and even sensations. (1992b, p. 87)

Herman (1992a, 1992b) argues, particularly, that chronically abused individuals show a pattern of constriction "in initiative and planning" because abusive environments destroy:

> ...the ordinary sense of a relatively safe sphere of initiative, in which there is some tolerance for trial and error. To the chronically traumatized person, any action has potentially dire consequences. There is no room for mistakes. (1992b, p. 91)

Recent work on the psychobiology of trauma (see Wilson, 1989 for a review of that work) provides further information regarding patterns of constriction seen in individuals with a history of abuse. Wilson (1989) argues that the constriction is, in part, an attempt to cope with symptoms of intrusion and re-experiencing typical of post-traumatic stress disorder, those symptoms being related to the physiological responses to exposure to inescapable or unavoidable aversive or traumatic events:

> Trauma victims...are often unaware of what triggers the reexperiencing and become fearful that they may be flooded with intrusive imagery unexpectedly. Modulating affect is often subjectively experienced as a difficult task. Consequently, the individual may develop compensatory symptoms of estrangement, detachment and emotional constriction in an attempt to avoid stimuli

> that may produce the previously conditioned all-or-none response....In this sense, overcontrol, isolation, and numbing evolve into elaborate defenses against the unexpected and unpredictable onset of distressing affect and imagery. (p. 32)

In addition, Wilson (1989) cites evidence for "distinct physiological mechanisms, apart from those involved in intrusive symptoms" (p. 32), in generating avoidance response (specifically, norepinephrine deletion and cholinergic response).

In summary, then, the effects of childhood abuse can be understood as existing on two levels. One level involves the content of the particular representations of self and world that develop in the context of an abusive environment. Such representations involve beliefs, assumptions, and expectations about self and others. They also involve beliefs, assumptions, and expectations about effective means of acting in the world in order to achieve particular ends. McCann and Pearlman (1990), for example, focus, in their work, on the schemas related to a number of "psychological need areas." While they distinguish schemas from other aspects of the self such as self-capacities and ego resources, it is also possible to conceptualize those aspects of self as schemas as well. That is, the self's ability to regulate emotional states is related to the individual's inner representations or beliefs, assumptions, and expectations about sources of comfort and so on. Problems arise when one's schemas or ways of organizing and understanding the world are maladaptive or pathological in the present.

The second level involves the effects of childhood abuse on the balance between maintenance of cognitive structures and the "remodeling and readaptation" of those structures in response to "the changeability of environmental situations" (Guidano & Liotti, 1983). Specifically, phenomena such as difficulties in coping in the present, continued use of maladaptive or problematic coping strategies, repetition of self-destructive patterns and so on all suggest difficulty in generating and using new information to facilitate growth and change.

It is clear from the individuals in this study that problems existed on both those levels. Many of the participants described beliefs about being unworthy of care, unlovable, and so on. Furthermore, all participants described established patterns of behaviour such as substance abuse, compulsive eating behaviours, compulsive sexual behaviours, self-mutilation, dissociation, denial, and relationship avoidance that were both problematic for those individuals and difficult to change.

As Herman (1992b) clearly identifies, change involves trial and error, which means that inherent in all change is risk. If one is to re-evaluate one's understanding of self and the world, if one is to re-evaluate one's cognitive structures, it may be necessary to make some tacit ordering processes explicit and it may be necessary to look at the information (in the broadest sense of that word) used in the construction of those structures. In other words, the two levels of content and process are interactive. It is more difficult to take risks when the consequences may involve the acknowledgement of what has previously been considered unbearably painful information.

Healing or recovery occurs when one's representations of self and the world change; what is more important to understand, however, is the process by which that occurs. Piaget (1975/1985) believes that change occurs through the processes of assimilation and accommodation. Assimilation involves the incorporation of new information into existing schema and the consequent elaboration of those structures. Accommodation occurs when the existing structures are not able to assimilate information presented and those structures are then transformed in such a way that assimilation can then occur.

Ford & Ford (1987) similarily talk about processes they describe as "self-construction" and "self-reconstruction." In the former case, change is produced through "progressive differentiation and elaboration of existing patterns of organization" (p. 41). Additions to one's behavioural repertoire and increases in one's skill level are seen as examples of the differentiation and elaboration of existing structures. Ford & Ford argue that self-construction is influenced by developmental flexibility and sequencing. The latter simply means, given that new development evolves from existing patterns of organization, some capabilities must develop before others. With respect to flexibility, Ford & Ford argue that:

> ...the greater the diversity of options in a person's behavioral repertoire, the less habitual their performance, and the fewer the prohibitions against alternate behavioral possibilities, the more diverse are the future developmental trajectories potentially available to that person. (p. 41)

In contrast to those kinds of incremental changes, the changes produced by "self-reconstruction" involve a process of disorganization and reorganization as the system responds to "severe disruptions of steady state patterns" (p. 42). In other words, when the system is unable to assimilate information, and unable to exclude it from awareness, then new patterns of organization are produced. The disorganization phase is associated, according to Ford and Ford, with "discomforting affect" and a greater openness to new options. The resulting reorganization may or may not be in the direction of greater psychological health; it will, however, result in a return to a state of stability.

Mahoney (1991), in describing Ilya Progogine's work on dissipative structures, notes that:

> ...dynamic systems [such as living systems] are always undergoing *perturbations*...that reflect the complex interplay of their internal self-organizing activities and their ongoing exchanges with their local environments. So long as these perturbations do not exceed the "balancing" capacities of the system, it moves onward (through space and time) at the same average level of organizational complexity....But the perturbations can get out of hand as a result of both outside and inside dynamics. If the perturbations exceed a certain threshold (the *bifurcation point*), a whole new level of principles is required to account for the processes that emerge. (p. 418)

Maturana and Varela (cited in Dell, 1985) argue that the nature of the changes that occur are "structure-determined." That is, changes that occur reflect the organization and structure of the organism. While changes are "triggered" in the course of the organism's "structural coupling" with its environment, they are not "produced" by that environment in the sense that interaction with any particular environment will produce a predictable result.

Bateson (1979) similarily asserts that, while the meaning of any experience is dependent on context, it is "the recipient of the message that creates the context" (p. 47). In terms of therapy relationships, that does not mean that what the therapist provides is of no account. However, it does mean that the client is an active participant in what Bateson describes as a stochastic process, that is, the combination of a random component and selective process "so that only certain outcomes of the random are allowed to endure" (p. 230). Bateson argues that skill in creating context is acquired either by learning or by "lucky mutation" which Bateson describes as "a successful raid on the random" (p. 47). However, Bateson says:

> The recipient must be, in some sense, ready for the appropriate discovery when it comes....*Readiness* [therefore] can serve to select components of the random which thereby become new information. But always a supply of random appearances must be available from which new information can be made. (p. 47)

The process of recovery begins with a decision on the part of the individual to seek change. For some of the participants in this study, that meant seeking a therapist with whom one could work. For others, it meant making a commitment to some group whose purpose was supporting change. For still others, it meant simply making a decision to participate in a therapy program that was offered. Regardless of the particular circumstances, a decision was made to try and find a way to make one's current situation or state of mind different. In Bateson's (1979) words, there was a state of "readiness" that allowed individuals to begin the process of making a connection with others who shared the goal of change in some form.

The specific actions of the other are "random" acts in the sense that it is impossible to predict the specific actions that will facilitate the development of that relationship. As was suggested earlier, the particular dynamics of the abuse experienced by any given individual will vary as will the context in which the abuse occurred and the meaning that became associated with the abuse. As a result, any particular action by a therapist may have a different meaning for any given individual. What may be perceived in a positive light by one individual, may be perceived in a negative light for another, or simply as unimportant to another.

Where there is a state of "readiness," however, there is an ability to act in relation to that environment in a way that will facilitate recovery. Many of the participants in the study talked about putting themselves in a situation they later identified as the beginning of the healing process. Heather, for example, talked about "being drawn" to doing work at a sexual assault centre. Within that environment, she created a familiar context, that is, she continued to act in relation to others in a caretaking capacity. However, being in that environment also allowed her to see that she had needs and issues herself with respect to the abuse she experienced in childhood. Furthermore, the conflict inherent in being in the roles of both helper and recipient of help allowed her to see that she needed to find a context for working that allowed her to focus on being the recipient of help. It is important to understand that the decision to seek such an environment is an act that represents the beginning of a change of understanding about what is possible in relationships.

It is also interesting to see that, in that particular state, individuals appear to have an ability to find signs that change is possible or to find signs of hope that do not intuitively appear to be so to others. Fiona's story, for example, about hearing the woman at an AA meeting talk about her fears of losing her sobriety of 14 years because of current difficulties in her life is not one that others might readily identify as one that inspires hope. Yet Fiona was able to draw from her environment something that encouraged her to take the next step.

In some instances, it seems understandable, in retrospect, why a particular encounter or incident would have a positive result. Diane's encounter with a therapist in the hospital whom she saw as accepting and supportive and responsible for giving her a sense of hope that "maybe she was worth saving" after all is such an example. What is significant in that situation, however, is that Diane allowed herself to experience those feelings and that she drew the conclusion she did from the experience. She did not have a long-term relationship with the therapist and might easily have drawn other conclusions, for instance, that even though others appear supportive, they cannot be counted on to be present in one's life for any period of time. Stories of suicidal individuals who do not commit suicide because of the smile of some stranger represent a similar phenomena--a random act from which the individual is able to select for a particular purpose at that time.

One way to understand that state of "readiness" is to see it in terms of the state of internal disorganization that Ford and Ford (1987) posit as resulting in increased flexibility in one's behavioural repertoires. More generally, that can be understood as increased openness to information that has the potential to result in a reorganization of one's representations of self and the world. In other words, at a time of disorganization, living systems are in a state of readiness for reorganization.

For individuals who enter therapy in a state of crisis, it is evident that their ways of organizing and understanding the world are in a state of disorganization. While that is less obviously the case with individuals who are not in a crisis state upon entering therapy, there are other indicators of disorganization of what might be termed the structures of meaning of the individual. Principal among those indicators is a sense of not being able to understand. In other words, the individual is unable to assimilate into existing representations some information that is in awareness. For example, Elizabeth talked about entering therapy because she "knew there was a reason why I was fat, and I didn't know why." Colleen, similarily, talked about not understanding the reasons why she couldn't cry, couldn't express her feelings, or allow herself to be vulnerable with others. Where relationships are problematic, there is often a sense of not understanding why or not understanding how one could act differently in the context of those relationships. The stories of participants in this study suggest that disruption of one's relationships (or feared disruption) is one of the major contributors to a state of disorganization as described here.

The action of searching for an environment that supports change involves taking a risk because it creates the possibility of further disorganization at the same time as it offers the hope that stabilization will ensue. Whether or not that risk is taken appears to depend on the degree of pain/discomfort associated with the state of disorganization and the perception of an option that would support change. While both are necessary to some extent, the experiences described by participants in the study suggest that the greater the degree of pain at the time, the less selective one needs to be with regard to possible options. For example, where individuals saw themselves in a position of choosing between an option such as suicide and seeking help, options that might not otherwise be considered were considered. In other cases, where the degree of immediate distress was less pronounced, there appeared to be either greater consideration given to the nature of the perceived resource or more faith, generally, in the ability of others to provide assistance.

The risk-taking evident in the search for an environment that will support change recurs at each stage of the healing process.[2] To the extent that the outcome of that risk-taking provides information that individuals perceive as useful in making desired changes, further risk-taking occurs. That process of recursive risk-taking is seen as central, or core, to change and recovery.

The development of a therapeutic relationship, or the creation of a context for healing, also involves risk-taking. Participants in this study often focused on the nature of the therapy relationship, or their particular healing context, and how that context facilitated the process of change. However, it was also clear from their stories that the client's role in creating such a context is as important as the therapist's.

The individual seeking change must take the risk of acting differently in that relationship in order for new information to be generated that will contribute to changing representations of self and others. Therapists' contributions to that process are not unimportant. However, it is the nature of the *interaction* between the individual and the therapist that results in changing representations of self and others.

The therapist must act in a way that new possibilities in terms of relationship become apparent. Nevertheless, unless the individual "tests" the therapist by taking some risk, however small, nothing has changed for the individual. He or she is continuing to operate on the basis of existing working models of self and others.

It is important to remember that internal working models are constructed not only on the basis of the actions of others in relation to self, but also on the basis of one's own actions in relation to those others. It follows, then, that any change in those working models involves a process of reconstruction that is based both on the actions of others in relation to self *and* one's own actions in relation to those others. One of the functions of the therapy relationship, then, is to provide an opportunity for the individual's representations of self to be broadened to include the possibility of different understandings of self and others. In a sense, what is being created is a parallel world. That new world does not replace or supplant the world of one's childhood; nothing will erase the experience of being abused as a child. It does, however, create another possible world in juxtaposition to the world of one's childhood.

Within that context, development of self occurs as well. In the same way that a child who grows up in a loving, nurturing environment develops internal resources, the creation of such an environment in adulthood creates the possibility of growth in one's internal resources. Again, that development requires action on the part of the individual; it does not follow automatically from the relationship context. In the same way that changes occur in representations of self and others in response to the generation of new information about relationships arising from interactions within a significant relationship, further changes in the representation of self can occur in relation to other contexts when new information is generated.

One of the other significant contexts for individuals is the relationship of self to self. The generation of new information, i.e., new possibilities, in that context requires different actions vis-a-vis the self. When individuals actively attend to their feelings and needs rather than directing attention away from self, that action generates new information. When individuals take some action to nurture or care for self, that generates new information. Those actions generate confidence in one's abilities, and they generate trust in self. When individuals actively seek to understand the basis of their behaviours and feelings, in the past and in the present, rather than assign blame, that provides new information. All of those kinds of activities have the effect of further broadening individuals' representations of self.

The changes in the representations of self and other that occur as a function of the relationship constitute part of the recovery process in and of themselves. However, those changes can also be understood as the construction of a different context for the individual in which the experiences of childhood can be re-appraised. As Bateson (1979) says, ""...nothing has meaning except it be seen in some context" (p. 14).

Researchers in the field of child sexual abuse have come to recognize that one cannot understand the effects of abuse without understanding the context in which it occurs. Alexander (1992), for example, argues that "any attempt to predict the onset of abuse and its long-term effects must include a consideration of the family context that mediates the experience of the abuse" (p. 185) and, further, that "a failure to consider the relationship context of sexual abuse ignores an important aspect of the long-term effects" (p.185).

In addition to the relationship context, the developmental level of the child at the time of the abuse is part of the general context in which the abuse occurred. The developmental level of the child influences the nature of causal attributions made (Allen, Walker, Schroeder, & Johnson, 1987), skills in moderating arousal (Thompson, 1990), the ability to create hypothetical possibilities, and so on. All of those factors have an effect on the meaning of the abuse for the individual.

The process of developing relationships that support recovery is a process of creating a new context. Within that new context, new possibilities are created. One is related to the ability to tolerate the pain associated with the abuse. The other is related to new ways of understanding one's experience.

In a context where individuals do not perceive that it is possible to obtain support from others, they become reliant on self to control that pain with whatever tools are available at the time. Often, that means that memories are dissociated or fragmented in some way in order to lessen the intensity of the experience. Knowledge of particular events may be excluded from consciousness, affect may be separated from knowledge that is retained, and so on.

An environment where support is offered and experienced provides a different context in which other actions become possible. When that is combined with a growing sense of one's internal resources, allowing oneself to re-examine the experience of one's childhood abuse becomes a possibility. Re-examining the experience involves the reconnection of the fragmented aspects of the experience in a new context.

Rieker and Carmen (1986) suggest that such reconnection "recontextualizes" the experience. In their view:

> The core of treatment must be to help the victim, in a safe and controlled way, to recall the abuse and its original affects and to restore the accurate meanings attached to the abuse: that is, to recontextualize the trauma. (p. 369)

Another way of understanding the process that avoids the difficulty associated with the notion of "accurate meanings" is to be able to examine the context in which the abuse occurred from the point of view of a different context. In other words, the experience is "recontextualized" in two senses of the word. When dissociated affect or dissociated bodily sensations or dissociated behavioural responses are reconnected to knowledge of particular events, they are given a context, or, are "recontextualized" in the sense that Rieker and Carmen describe. However, the abuse is also recontextualized in the sense that it is now being experienced, through reactivation in memory and narration, as an adult with greater resources, in a supportive environment. It is that experience that allows for the possibility of generating new interpretations and a different understanding of what occurred in childhood.

Herman (1992b) describes the role of the therapist in this stage of the healing process as providing a context in which the reconstruction of the individual's story can occur:

> Throughout the exploration of the trauma story, the therapist is called upon to provide a context that is at once cognitive, emotional, and moral. The therapist normalizes the patient's responses, facilitates naming and the use of language, and shares the emotional burden of the trauma. She also contributes to constructing a new interpretation of the traumatic experience that affirms the dignity and value of the survivor. (p. 179)

However, the context to which she refers is not the sole creation of the therapist. Although a therapist has an important role in that process, the context is, more accurately, a co-creation of therapist and client. Similarily, the client has an active role in the recontextualization of the abuse in both senses of the word as described above.

While participants in the study described the spontaneous emergence of memory fragments, the reconnection of those fragments always involved some action on the part of the individual. In some cases, that action was simply a decision to "notice" other related fragments (e.g., images, feelings, sensations). In other cases, the action involved a conscious decision to search for related fragments, using a variety of formal or informal techniques.

As with other actions directed at recovery, risk is involved. The individual does not know what exactly will emerge, nor does she or he know exactly how others will respond to what emerges. As Elizabeth said, even after six years in therapy, there are times when she is apprehensive about how her therapist will respond to a new "level" of memories. How one's therapist does respond is information that is added to the memory of the abuse in the reappraisal of the experience. From a theoretical perspective, the concept of social referencing (Campos & Stenberg, cited in Campos, Campos, & Barrett, 1989) is useful in understanding that process.

The information provided by the therapist's response leads to the possibility of interpreting one's experience in a different way. In order for that to occur, however, the individual needs to understand, on various levels, the meaning that the experience originally held. In other words, in order for structures of meaning to change, the various components of that structure need to be accessed as a whole. As long as cognitive, affective, and somatic components of the experience are dissociated, some information used in the construction of meaning is unavailable for reappraisal.

It is important to remember, however, that the dissociation of one's experience, and the avoidance of certain stimuli or the constriction of awareness to limit spontaneous reassociation, are defensive mechanisms designed to prevent the individual from being overwhelmed with negative affect. Furthermore, one's sense of identity is integrally related to the structures of meaning that have been constructed in the course of one's development. It is, therefore, important that the process of re-examining the abuse and reappraising its meaning be gradual and that both therapist and client be cognizant of the need for pacing.

Many of the participants in the study described periods of crisis where they felt overwhelmed by the feelings related to their abuse as children that were surfacing and the need to learn to "shut down" and well as "open up." Several of the participants also described a sense of losing their identity, either during the period when memories of the abuse first emerged or in response to realizing that it was possible to understand the abuse differently and to construct a different self who was not, as Helene said, a "creature of the abuse."

Helene describes a point in therapy where the individual, having become aware of other possibilities, is called upon to make a decision about who she or he will become. She says, in reference to an acquaintance:

> ...she was at that point that I think everybody gets to in therapy where you've really grown. This person inside of you who is the person of the abuse, the creature of the abuse...that creature gets less and less powerful...then what you have is a great big black hole in the middle of you, and I think it's the scariest moment in therapy....And then you have to decide whether the creature of the abuse is going to control your life or whether you are going to build somebody else in there.

What Helene was able to articulate is a shift that was apparent for all the participants who saw themselves as nearing the end of the therapy process. Up until that time, the process is one of generating new possibilities in terms of relationships with others, new possibilities in terms of one's relationship with self, new possibilities for understanding one's past and its effects on one's life in the present, and so on.

As was previously suggested, the creation of a new context that does not replicate the patterns of one's abuse is, in essence, the creation of a parallel world, a new possibility. The retrieval and exploration of one's past places the world of one's experience in sharp relief to the parallel world that has been created. In doing so, it makes clear that the world of one's past is not the only possibility. It allows individuals to see their actions as occurring within a particular context rather than being manifestations of an unchangeable self. In other words, it allows one to understand differently. It also means that choice is possible in one's life. It means that one is able to choose, in Helene's words, "to build somebody else in there."

Bateson (1979) argues that learning does not involve simply the learning of behaviour; it also involves "second-order" learning which he describes as the learning of context. His description of how that learning occurs is very similar to the process suggested here:

> ...this learning of context springs out of a species of double description which goes with relationship and interaction. (p. 134)

In other words, when individuals take the risk to engage in a relationship where the dynamics of the relationship do not replicate the dynamics of the abuse, and when they take the risk to change their pattern of interaction with others in that relationship, a new context is created. More important, however, is that, in creating a new context, individuals learn that it is *possible* to create a new context and, thereby, to "re-create" self.

That realization, as Helene suggests, may be overwhelming at times. The re-creation of self is not an easy process. The past, however painful, and the coping skills one has developed in the context of that past, however imperfect in the present, are familiar. Choosing to create a new world and to re-create oneself involves a leap into the unknown in many ways. Nor is it a decision that is made only once. It is a decision that is made over and over again as the individual takes another and another risk to act differently. However, it is those actions, that is, the changes that the individual makes in relationships with others and with self, that result in the re-creation of self.

This is the stage in the process of recovery described in this study as "making changes." The role of the therapist at this stage continues to be important, although many of the participants described a shift in their needs at this point in therapy as they began to more clearly direct the course of their lives. At this stage, the therapy relationship often served as a "secure base" for the individual. The role of the therapist in that context was primarily the provision of support, encouragement, feedback, the identification of alternative actions, and assistance in skill development in response to particular changes that individuals were attempting to make.

It is also a time in the recovery process where it is most obvious that individuals are taking risks with respect to new behaviours. It is not, as suggested previously, the beginning of risk-taking behaviour. There is, however, a perceptible shift, in the nature of that risk-taking behaviour, or perhaps, more accurately, a shift in attitudes regarding risk-taking behaviours.

In the early stages of the recovery process, there is clearly a sense that risks are taken because individuals are in a state of psychological distress that they are unable to manage, and no other options are apparent. Participants in later stages tended to see risks as challenges that allowed them to test beliefs about self, to gain new information, to develop new skills, and to grow. That shift in perspective is clearly seen in Elizabeth's description of the motivation for change:

> There is a point in healing where it shifts and it really is--it's struggle and it's push and it's almost like there has to be something--there has to be such a level of discomfort that it keeps me going, getting there. And then the payoff starts to happen and then there is very much a turning point where, suddenly, the payoff is greater than the--and then, suddenly, I want to, I want to do this.

In essence, what happens in the course of recovery is that, not only do beliefs, assumptions, and expectations of self and others change, but that the "survival mode" of functioning that Chemtob et al. (1988) describe changes. Where needs for safety or love are not met, children learn to avoid "genuine relational connections" (Stiver, 1990, p. 2). In order to protect themselves, individuals limit the range of interactions with others and limit both awareness of aspects of self and, in some cases, awareness of events that threaten the relationships that exist. As a result, a sense of isolation or disconnection from others develops as well as a sense of disconnection with self.

The process of recovery involves the development of connection with others, often primarily a therapist, but also with others who share similar experiences. It involves the development of a sense of connection with self, which includes the reconnection of dissociated aspects of one's experience. Individuals learn to make those connections through a process of recursive risk-taking in an environment of safety and support, where the process of trial and error upon which learning is based does not engender unacceptable levels of risk. The "corrective information" (Foa and Kozak, 1986) provided in the process allows individuals to begin to revise their representations of self and others.

At the same time, however, there is a second order of learning that is occurring. Individuals are learning to take progressively greater risks. They are learning that change involves taking risks to challenge old beliefs and assumptions, and they are learning that new information and new possibilities are created through taking the risk to act differently. They are learning, in essence, how to change. As the participants in the study said, nothing can erase the experience of being abused as a child; one never comes to the point where it is as if the abuse never occurred. What can happen, however, is that individuals learn to make a life in the present that is not limited by their past.

Chapter VI
Conclusion

The purpose of this study was to develop an understanding of the process of recovery from childhood sexual abuse that was based on the experience of survivors of abuse who had made significant progress toward that end. In particular, the goal was to determine if there was an identifiable pattern of recovery and to identify therapist behaviours that facilitated recovery in order that therapists might better assist survivors in that process. From a more theoretical perspective, the goal of the study was to use the experience of the participants in the study to generate hypotheses about the nature of the change process in general.

The research method used in this study was designed to assist the researcher in keeping the theory grounded in the data. As in any study, the selection of an appropriate and adequate sample is necessary to ensure that the theory developed is "credible." Lincoln and Guba (1985) have suggested a number of procedures as checks on credibility.

One method suggested is to reserve data that may subsequently be used to assess the credibility of the model. In this study, one interview was not included in the development of the model, but was retained for that purpose. The subsequent analysis of that interview shows a pattern that is consistent with the model developed in this study. In particular, the interview showed:

- The beginning of a search for help marked by a recognition that "something was not right." No memories of sexual abuse existed at that time.
- The establishment of a sense of connection, at first with other survivors, later with a therapist.
- Variables related to family context (in particular, persistent negation of perceptions and attribution of

perceptions contrary to father's presentation of reality to mental illness) that influenced:
  (a) issues of particular importance in making connection (validation, normalization), and
  (b) issues of particular importance in strengthening the self (learning to trust self).

- The gradual recovery of memories which provided information which was important in understanding behaviours as a child and behaviours as an adult.
- Imaginal exploration of new possibilities.
- Specific changes in behaviour (changing interactions with family of origin members which increasingly involved a refusal to be drawn into family games, differences in the expression of anger, learning to state needs in relationships with others).
- The clear recognition that one's present life need not replicate the dynamics of one's childhood, i.e., that change is possible.
- A pattern of learning to make changes through a process of risk-taking in various settings.

The reservation of data for subsequent review allows the researcher to make an assessment of the degree to which the additional data fits the model developed. However, the very nature of the research process makes it difficult to approach that data without a predisposition for finding confirming evidence. One of the other methods for assessing credibility is to have the results reviewed by individuals who did not participate in the study but who would meet the criteria for participation. Although this was not done in any formal way for purposes of this study, informal feedback was received that suggests the theory developed fits the experience of individuals who reviewed the results. A more formal review might form the basis of further research.

The extent to which the model developed in this study is applicable to other individuals depends on the degree of similarity between those individuals and their situations and individuals in this study. Defining those parameters is important in specifying the extent to which the results of this study are "transferable." One issue that merits further consideration is related to gender. This study included two men in the sample; however, none of the therapists who referred participants were male. As a result, participants generally described their experience in working with female therapists.

With respect to the gender of clients, there is nothing in the study to suggest that the process of recovery differs for men and for women. However, it was clear that the content of some of the issues varied, as would be expected given the differing social context for males and females. Social context is a factor in the development of representations of self and others in a number of ways. Social stereotypes provide an idealized reference point for judging the perceived adequacy of self. They also influence the judgments of others and, in that way, have an indirect effect on the development of one's representations.

As a result, women and men may have negative evaluations of self for different reasons. As Stephen indicated in the interview, one of the most difficult issues he faced was related to his belief that his inability to protect himself from sexual assault was evidence of his weakness and "unmanliness." The link between particular behaviours and sexual identity appears to be stronger for men than for women, although that is clearly an area of research needing more investigation.

For women, negative evaluations of self were more often related to issues such as aggressive behaviour and failure to protect children. While those apparent differences are of interest and might merit further investigation, what is central in terms of the process of change is an understanding of the genesis of negative feelings/beliefs about self, whatever they are, and the development of self-acceptance.

Similarily, there appear to be some differences in the response of males and females to victimization in childhood related to socialization, although there are not distinct patterns of response by sex. However, compulsive sexual behaviour appears to be more common for men than for women as does aggressive acting-out. In terms of recovery, the nature of the specific pattern of response does not appear to be of major relevance. In all cases, change requires an awareness of what triggers the response, the identification of other possible responses, and risking new behaviour.

The issue of gender differences is a complex one. In addition to differences in social context, there also appear to be differences in the nature of the abuse experienced by males and females. Gordon (1990), in analyzing the results from the 1985 Los Angeles Times poll, found that males were more likely to report being older at the age of first abuse, more likely to report being abused by non-relatives outside the home, and more likely to report severe abuse that was not previously disclosed. All of those differences have the potential to influence beliefs about self and others and responses.

Another area that merits investigation relates to the possibility that there are differences in the relationships between female therapist and female client, female therapist and male client, male therapist and female client, and male therapist and male client that are salient to the process of recovery. It is clear from this study that the therapy relationship is an extremely important element in the recovery process. The fact that there were no referring male therapists made it impossible to identify possible differences between male and female therapists in their work with clients. In the situation where male participants in the study had female therapists, there was no evidence of any significant differences between those relationships and the relationships between female therapists and female clients. It would be interesting, however, to examine that issue from the therapists' point of view as well to ascertain whether therapists are aware of responding differently to male and female survivors.

One of the goals of this study was to develop a model of the recovery process that was trans-theoretical in nature. The goal was not to understand the process of change from a cognitive-behavioural paradigm or a psychodynamic paradigm, but rather to identify, from the point of view of individuals dealing with the negative effects of childhood abuse, basic elements involved in recovery and change. The study does that. It was possible in the study to look beyond particular techniques used and focus on the function that those techniques served in promoting change.

However, different schools of thought differ in more than technique; they also differ in regard to basic assumptions about change itself. While interviewing clients is apt to result in less technical descriptions of the change process than interviewing therapists, the assumptions held by clients about what contributes to recovery and change are not likely to be dramatically dissimilar to the assumptions held by their therapists, particularly in longstanding relationships. It is, therefore, important that the sample include individuals who have worked with therapists of differing theoretical orientations.

An attempt was made in this study to solicit referrals from therapists with different training backgrounds and theoretical orientations. To some extent, that resulted in variation in the therapeutic approach that influenced participants' experience. However, that range was limited by the size and diversity of the community of individuals with expertise in the area known to the researcher. It is, therefore, possible that a more diverse therapist sample would have resulted in a model that was different or more detailed in some way. One way in which future research might address this issue is to compare the understanding of the change process that clients working with therapists with very different orientations have.

Future research might also address issues related to the process of recovery from a microscopic, rather than macroscopic, perspective. The retrospective nature of this study means that there is a level of detail about the process of recovery that is impossible to capture. As indicated in Chapter III, the decision to proceed in that manner was deliberate because of the perceived need to establish a general framework for understanding the process. The fine-grained analysis of individual sessions is not suited to the development of a model to explain a process that may involve hundreds of hours in therapy as well as a multitude of non-therapy experiences. However, that level of detail may be very important in developing a better understanding of some element of the process. There are a variety of approaches, particularly approaches involving the researcher as observer, that might be used to provide more detailed information that would complement the results of this study.

The value of the model developed in this study is that it does provide a general framework for understanding the process of recovery from childhood sexual abuse. It does suggest that there is a common set of stages involved in recovery as well as describing the means by which individuals move from stage to stage. Although the specific focus of this study is the process of recovering from the negative effects of childhood sexual abuse, there are clear implications related to our understanding of change generally.

For change to occur, an individual's understanding of self and others must change. For that to occur, the individual must be able to use information that challenges old beliefs, and the individual must be able to generate new possibilities based on previously unconsidered information. Developing the ability to do so is a learning process which involves taking risks in an environment where doing so is supported and encouraged, regardless of outcome. Learning to see self and others differently in the context of therapy is important. What is perhaps more important, however, is developing the flexibility that permits adaption to a variety of contexts and the knowledge that one can, through one's own actions, play a part in the creation of new contexts.

FOOTNOTES

[1] This conceptualization draws from Braun's (1988) BASK model of dissociation which describes dissociative disorders as resulting from the dissociation of behaviour, affect, sensation, and knowledge.

[2] I am indebted to Dr. Allen Vander Well for his assistance in identifying this core category.

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Appendix A

Request for Research Participants

PARTICIPANTS NEEDED FOR RESEARCH PROJECT ON THE PROCESS OF RECOVERY FROM CHILDHOOD SEXUAL ABUSE

I am a graduate student in the Counselling Psychology Program in the Department of Educational Psychology at the University of Alberta.

I am looking for individuals with a history of childhood sexual abuse who have been in therapy and believe that they have made substantial progress in recovering from the negative effects of that abuse.

The research will involve meeting with me for approximately 1 1/2 hours to talk about the process of recovery. Interviews will be tape recorded and later transcribed in written form. The information provide will then be analyzed to see what common experiences emerge.

Interviews will be considered confidential, and participants will not be identified in written transcripts or in the research report. All tapes will be erased when the research is completed.

It is my belief that the information provided by participants will be useful to therapists helping clients in the recovery process and, perhaps, to individuals involved in that process themselves.

If you would be willing to participate in the study, please contact Dorothy Constable at 428-0817.

Appendix B

Covering Letter from Therapist

March 20, 1992

Dear

I have been contacted by Dorothy Constable who is a graduate student in the Counselling Psychology Program at the University of Alberta regarding her doctoral research. She has asked that I forward information about her research project to former clients who might be willing to participate in the study.

I have attached a description of the project which she has provided to me. If you would be interested in participating, please contact her at 428-0817.

Sincerely,

Appendix C

Interview Guide

1. Terminology: "process of recovery"/"healing"/"dealing with the abuse." How do you conceptualize the process?

2. Set framework for the interview: I am interested in that process, specifically, what that process has been for you, how it began, what happened over time, where you are now, as well as what has helped you to make changes.

3. What is your sense about how the process began for you? What initiated the process?

   Probes:

   What was happening for you at the time?
      Some "final straw"?
      Some change in your situation that made doing something an option at that point when it had not previously been so?

   If therapy, how did you go about finding someone and what was the process of getting established in therapy (or group) like for you?

   What do you remember of early therapy sessions (your feelings, therapist actions, your reactions).

   What expectations did you have at the time about what would happen?

4. What happened over time for you? (e.g. in therapy).

   Probes:

   Did you have any sense of things changing for you? If so, what changed?

   Were there any specific things that stand out in your mind that made you realize that you had changed/were changing?

   What helped that change occur for you?

   Were there any specific times/incidents that stand out in your mind as being particularly helpful or particularly significant in some way?

   What were the major issues for you in therapy?

What was the biggest thing you had to overcome and/or were there any "stuck points" for you? What helped you to overcome that/move past that stuck point?

Did you feel that you experienced any setbacks during the process of recovery? How did you overcome the setback(s)/what helped?

Were there any times where a therapist did something unhelpful? What was unhelpful/in what way?

5. Where are you now in the process? Unresolved issues? Changes you still want to make? What is "recovery"?

6. What has changed for you in the process of dealing with the sexual abuse?

   Probes:

   Internal vs. external changes (visible to others).

   Changes in feelings, thoughts (beliefs), behaviours.

   In what order did those changes occur?

   What changes were easiest/hardest for you?

7. Reflections on the interview; reason for agreeing to participate; expectations; debrief feelings about participation; future involvement (e.g. transcripts, results).

Appendix D

UNIVERSITY OF ALBERTA
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

Participant Consent Form

PROJECT TITLE: Recovering from Childhood Sexual Abuse
INVESTIGATOR: Dorothy Constable Telephone: 428-0817

The purpose of this research project is to increase our understanding of the process by which adults recover from the negative effects of childhood sexual abuse. Interviews with research participants will be conducted by Dorothy Constable, graduate student in the Department of Educational Psychology, University of Alberta.

THIS IS TO CERTIFY THAT I, ________________________________, HEREBY agree to participate as a volunteer in the above named research study.

I understand that, while no negative effects are expected as a result of my participation, referral to an appropriate service will be offered, if needed.

I give permission to be interviewed and for the interview to be tape-recorded and subsequently transcribed into written form. I understand that pseudonyms, not real names, will be used in the written transcripts. I further understand that the tapes will be erased when the research is completed.

I understand that the information provided by me will be used solely for research purposes. I understand that the results of the research may be published, but my name will not be associated with the research and every effort will be made to remove any identifying information.

I understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been give the opportunity to ask whatever questions I desire, and all questions have been answered to my satisfaction.

________________	________________	________________
Participant	Researcher	Date